

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-046646

FILED VS JAN 20 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 399

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| 1. PLACE OF DEATH a. COUNTY <u>ADAIR</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ADAIR</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKSVILLE</u> | | Length of stay in lb <u>2 DA.</u> | c. CITY OR TOWN <u>BRASHEAR,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LAUGHLIN HOSPITAL</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>NORTH BRASHEAR</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>LOUIS</u> Last <u>CROCKETT</u> | | | 4. DATE OF DEATH Month <u>DEC.</u> Day <u>20</u> Year <u>1959</u> | | | |
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| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>CAUCASIAN</u> | 7. Married <input checked="" type="checkbox"/> - Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 22, 1922</u> | 9. AGE (last birthday) <u>37</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-----------------------|--------------------------------------|---|--|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | 11. BIRTHPLACE (City and state or country) <u>ST. JOSEPH, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>LOU J. CROCKETT</u> | 13b. MOTHER'S MAIDEN NAME <u>CLARA GORDON</u> | 14. NAME OF HUSBAND OR WIFE <u>MARLEINE SMITH</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>493-18-2373</u> | 17. INFORMANT <u>MRS. NORMAN CROCKETT BRASHEAR Mo</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> |
| IMMEDIATE CAUSE (a) <u>FULMINATING SEPTICEMIA</u> | | |
| DUE TO (b) <u>GRAM NEGATIVE BACILLUS (POSSIBLY BRUCELLA)</u> | | |
| DUE TO (c) _____ | | |

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal event <u>ACUTE HEMORRHAGIC NEPHROSIS OF KIDNEYS - TOXIC NECROSIS OF LIVER - ADRENAL HEMORRHAGE - SHOCK</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year |
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|--|--|---|------------------------|---------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>KIRKSVILLE, MO</u> | COUNTY <u>ADAIR</u> | STATE <u>MO.</u> |
|--|--|---|------------------------|---------------------|

21. I attended the deceased from 12-18-59 to 12-20-59 and last saw him alive on 12-20-59
Death occurred at 2:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|-------------------|--------------------------------------|------------------------------------|
| 22a. SIGNATURE <u>Paul Laughlin Jr. Do</u> | (Degree or title) | 22b. ADDRESS <u>Kirkville, Mo</u> | 22c. DATE SIGNED <u>1-14-60</u> |
|---|-------------------|--------------------------------------|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>DEC 22, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>SABBATH HOME</u> | 23d. LOCATION (City, town, or county) <u>NORTH BRASHEAR Mo.</u> | (State) |
|--|----------------------------------|---|--|---------|

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| 24. FUNERAL DIRECTOR <u>Paul Rogers</u> | ADDRESS <u>Brashear Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>1-18-1960</u> | 26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u> |
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*Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EARL LAURENCE, JR., D.O.

JUN 14 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me or by KENNER ROGERS, Student Embalmer No. 582

working under my personal supervision.

Student Kellen Rogers
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.