

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004853

INDEXED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 16 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>DOUGLAS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWNSHIP</u>		Length of stay in 1b <u>3 MONTHS 11 DAYS</u>	c. CITY OR TOWN <u>DOUGLAS AVA</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSP. #3 NEVADA MO</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>- - -</u>

3. NAME OF DECEASED (Type or print) First <u>OTTIE</u> Middle <u>-</u> Last <u>BRAZEALE</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 5. 1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	11. BIRTHPLACE (City and state or country) <u>ARKANSAS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>JACOB DARDEN</u>		13b. MOTHER'S MAIDEN NAME <u>IRONE ELLISON</u>		14. NAME OF HUSBAND OR WIFE <u>WALTER BRAZEALE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	17. INFORMANT Address <u>STATE HOSP. #3 NEVADA MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>- - -</u>		-
DUE TO (c) <u>- - -</u>		-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GENERALIZED ART. SCLEROSIS MANY YEARS</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	Month, Day, Year <u>- - -</u>	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>- - -</u>	COUNTY <u>- - -</u> STATE <u>- - -</u>

21. I attended the deceased from OCT. 14. 1959 to JAN. 25. 1960 and last saw her alive on JAN. 25. 1960
Death occurred at 9:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Leslie H. Wright, M.D.</u>	22b. ADDRESS <u>STATE HOSP. NEVADA MO</u>	22c. DATE SIGNED <u>1-25-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/28/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>AVA</u>	23d. LOCATION (City, town, or county) (State) <u>AVA, MISSOURI</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Clinkenbeard AVA, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 3 - 1960</u>	26. REGISTRAR'S SIGNATURE <u>Arma J. Jarry</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lloyd C. McNeil

Licensed Embalmer No. 4853

P. O. Address Flordia, FL

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.