

1. PLACE OF DEATH a. COUNTY Cape Girardeau			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Cape Gir		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 1607 Broadway		Length of stay in 1b 40 yr	c. CITY OR TOWN Cape Girardeau		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Southeast Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1607 Broadway	
3. NAME OF DECEASED (Type or print) First Antonie Middle Brandes Last McLain			4. DATE OF DEATH Month Feb Day 12 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1892	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months 9 Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Uniontown Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME August Brandes		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 491-36-2431		17. INFORMANT Address Miss Virginia McLain, Cape Gir Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Judiciary Ecchymosis DUE TO (b) Septic Reticulosis cell Sarcinosa Stomach DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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
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 _____ a.m. _____ p.m. Month, Day, Year _____					
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 COUNTY STATE	
21. I attended the deceased from 2-1-60 to 2-12-60 and last saw her ^{her} _{him} alive on 2-12-60 . Death occurred at 6 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Frank Hall M.D.			22b. ADDRESS Cape Girardeau, Mo		22c. DATE SIGNED 2-16-60
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial		23b. DATE 2-15-1960	23c. NAME OF CEMETERY OR CREMATORY Fairmount		23d. LOCATION (City, town, or county) (State) Cape Girardeau Mo.
24. FUNERAL DIRECTOR ADDRESS Brinkopf Howell, Cape Gir Mo.			25. DATE RECD. BY LOCAL REG. 2-17-60	26. REGISTRAR'S SIGNATURE Gene Kasten	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 15 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Neil H. Grosshailer

Licensed Embalmer No. 4994

P. O. Address Capo Girardeau

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.