

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018144

FILED VS MAY 9 1960

373

Primary Registration District No. 6265

Registrar's No. 22

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>S. GRANT TWP.</b>		Length of stay in 1b	c. CITY OR TOWN <b>CONWAY MO RI</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>9mi. N. MARSHFIELD</b>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>OREN</b> Last <b>BRAVES</b>			4. DATE OF DEATH Month <b>APR</b> Day <b>30</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-7-1918</b>	9. AGE (last birthday) <b>42</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>
13a. FATHER'S NAME <b>JACK BRAVES</b>		13b. MOTHER'S MAIDEN NAME <b>LUCY HOLLIS</b>		14. NAME OF HUSBAND OR WIFE <b>CLAYDE BRAVES CONWAY MO RI</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>486-24-2301</b>		17. INFORMANT <b>CLAYDE BRAVES CONWAY MO RI</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXSANGUINATION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>25 MIN.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ABDOMINAL GUNSHOT WOUND</b>					
DUE TO (c)					
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 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 checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>WAS SHOT WITH A .22 PISTOL</b>	
20c. TIME OF INJURY <b>12:15 a.m.</b>	Hour <b>4-30-60</b>	Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>CAFE</b>	20f. CITY, TOWN, OR LOCATION <b>RT 1 STAFFORD</b>	COUNTY <b>WEBSTER MO.</b>	STATE	
21. I attended the deceased <b>FOR 30 MIN.</b> to _____ and last saw him alive on <b>4-30-60</b> Death occurred at <b>1240 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>[Signature]</b>			22b. ADDRESS <b>Marshallfield, Mo.</b>		22c. DATE SIGNED <b>5/2/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-1-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST DUKE</b>	23d. LOCATION (City, town, or county) <b>WEBSTER CO MO</b>		
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD</b>			25. DATE RECD. BY LOCAL REG. <b>5-5-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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

*George Stapp*

Licensed Embalmer No. 3461

P. O. Address Mt. Brown

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.