

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 20 1960

-60-025446

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 36

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>STE. GENEVIEVE</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ZELL</u>		c. CITY OR TOWN <u>ZELL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <u>LIFE</u>		d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STAR ROUTE # 2</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>JOHN</u>		Middle <u>N.</u>		Last <u>BRAUN</u>		Month <u>JUNE</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>6/8/75</u>	9. AGE (last birthday) <u>85</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>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>ZELL MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>ANTON BRAUN</u>			13b. MOTHER'S MAIDEN NAME <u>MARY JACOB</u>			14. NAME OF HUSBAND OR WIFE <u>ELIZABETH SCHWENT</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. _____		17. INFORMANT <u>Norman Braun Sr. Geneva Mo</u>		Address <u>STAR ROUTE # 2</u>	
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	
IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>						<u>10 yal.</u>	
DUE TO (b) <u>Arteriosclerosis</u>						?	
DUE TO (c) <u>Bronchial pneumonia</u>						<u>3 days</u>	
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 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 <u>Feb 2, 1960</u> to <u>June 16, 1960</u> and last saw ^{him} alive on <u>June 13, 1960</u> Death occurred at <u>6:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Dr. Lansing M.D.</u> (Degree or title)				22b. ADDRESS <u>St. Genevieve Mo</u>		22c. DATE SIGNED <u>6/17/60</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	23b. DATE <u>6/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST JOSEPH</u>		23d. LOCATION (City, town, or county) <u>ZELL</u>		(State) <u>MO</u>	
24. FUNERAL DIRECTOR <u>Geo. C. Baskin Sr. Genevieve Mo</u>			ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>6/18/60</u>	26. (REGISTRAR'S SIGNATURE) <u>Louis Baskin</u>	

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 Adrian J. Elder

Licensed Embalmer No. 4746

P. O. Address St. Dennis

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.