

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026092

FILED VS. JUL 19 1960

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 196

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>app. 2 wks.</u>		c. CITY OR TOWN <u>California</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Brizendine</u> Last <u>Brizendine</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>2-13-1880</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>			11. BIRTHPLACE (City and state or country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>unk</u>				13b. MOTHER'S MAIDEN NAME <u>unk</u>				14. NAME OF HUSBAND OR WIFE <u>unk.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>				16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT Address <u>State Hospital No. 1 Fulton, 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>Pulmonary Acidosis</u>										INTERVAL BETWEEN ONSET AND DEATH			
DUE TO (b) <u>Pulmonary Emphysema with Chronic Bronchitis</u>													
DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease, Chronic Brain Syndrome</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			
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.)									
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					
State Hospital No. 1				6-27-60		7-11-60		XXXXXXXXXXXX					
21. <input checked="" type="checkbox"/> attended the deceased from _____ to _____ Death occurred at <u>9:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>William V. Tarrell M.D.</u>						22b. ADDRESS <u>Fulton, Mo.</u>			22c. DATE SIGNED <u>7-11-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>July 14, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) <u>California</u>		(State) <u>Mo</u>					
24. FUNERAL DIRECTOR <u>Wallace Funeral Home Fulton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>July 12-1960</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</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 *A. R. Maxwell*

Licensed Embalmer No. 4996

P. O. Address Fulton, N.Y.

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.