

# MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-027816

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 263

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Pettis</b> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>901 S. Harrison</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b> c. CITY OR TOWN <b>Sedalia</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>901 S. Harrison</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>SAMUEL</b> Middle <b>W.</b> Last <b>BRANSTETTER</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>25</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sep. 4, 1893</b>	<b>9. AGE (last birthday)</b> <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Painter &amp; Int. Decorator</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Painting</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Fayette, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>William Branstetter</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Rosie</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Matilda May Branstetter</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>W.W. I WW I -</b>		<b>16. SOCIAL SECURITY NO.</b> <b>491-07-6595</b>		<b>17. INFORMANT</b> <b>Mrs. Matilda Branstetter, Sedalia, Mo</b>			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Chronic myocarditis and renal disease. Loss of blood from kidneys and chronic anemia.</b> DUE TO (c) <b>Not known</b>		INTERVAL BETWEEN ONSET AND DEATH  _____
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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"/> N <input type="checkbox"/> Unknown		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> <b>No</b>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) -----			
<b>20c. TIME OF INJURY</b> Hour _____ s.m. _____ p.m. _____ Month, Day, Year _____		-----			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	

21. I attended the deceased from July 23rd to July 25th and last saw her/him alive on July 25th  
 Death occurred at 6:00 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>L. A. Maitz M.D.</i>	<b>22b. ADDRESS</b> <b>602 West 16th St., Sedalia</b>	<b>22c. DATE SIGNED</b> <b>7-26-60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>July 28, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park Cemetery</b>	<b>23d. LOCATION (City, town, or county) (State)</b> <b>Sedalia, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>D.W. Heckart - Sedalia, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>July 28, 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Frances Shelby</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 4 1960

SEP 2 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 Richard J. Conn

Licensed Embalmer No. 4703

P. O. Address Sedalia, Mo

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