

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 11 1960

53

3010

394

-60-034064

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CAPE GIRARDEAU		Length of stay in 1b 7 DAYS	c. CITY OR TOWN CHAFFEE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 401 BLACK AVE.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First IRA Middle BRAZEAU Last BRAZEAU			4. DATE OF DEATH Month Oct. Day 2 Year 1960		
---	--	--	---	--	--

5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months 11 Days 9	IF UNDER 24 HR Hours Min.
---------------------	-------------------------------	---	---------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACT FOREMAN	10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (City and state or country) MANFIELD MO	12. CITIZEN OF WHAT COUNTRY U.S.A
---	--	--	---

13a. FATHER'S NAME JAMES BRAZEAU	13b. MOTHER'S MAIDEN NAME EMELINE MOORE	14. NAME OF HUSBAND OR WIFE LOLA BRAZEAU
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. 108-818160	17. INFORMANT Mrs. Lola BrazEAU	Address
---	--	---	--------------------

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 5 MOS.
IMMEDIATE CAUSE (a) Uremia		
DUE TO (b) Nephrosis; nephrotoxi		
DUE TO (c) Duodenal ulcer; phlebitis; Chr. myocarditis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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 CHAFFEE	COUNTY SCOTT	STATE MO
--	--	--	------------------------	--------------------

21. I attended the deceased from **May, 1960** to **October 2, 1960** last saw him live on **October 2, 1960**
Death occurred at **11:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. O. Finney	(Degree or title) M.D.	22b. ADDRESS Chaffee, Missouri	22c. DATE SIGNED 10/4/60
---------------------------------------	----------------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE 11-4-1960	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) CAPE GIRARDEAU MO
---	-------------------------------	--	---

24. FUNERAL DIRECTOR STUBBS FUNERAL HOME	ADDRESS CHAFFEE	25. DATE RECD. BY LOCAL REG. 10-6-60	26. REGISTRAR'S SIGNATURE Drene Kasten
--	---------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 T T 190

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 Eugene L. Stubbins

Licensed Embalmer No. 5012
P. O. Address Chaffee, M

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.