

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041888

FILED VS NOV 17 1960

149

Primary Registration District No. 1002 Registrar's No. 5394

5394

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City			length of stay in 1b 19 days 37 yrs		c. CITY OR TOWN Grain Valley		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) RR # 1		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MR. FRED GODFREY BRIXNER				4. DATE OF DEATH Month Day Year Oct. 25, 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-22-1891	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster			10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (City and state or country) Teriol, Austria		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Adele M. Brixner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 489-30-0987		17. INFORMANT Address Mrs. Adele Brixner--Grain Valley, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage.							INTERVAL BETWEEN ONSET AND DEATH 10/5/60	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Rupture of Artery of left Middle Cerebral Artery.								
DUE TO (c) Cerebral arteriosclerosis.								
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 10/6/60 9:10 P. to 10/25/60 and last saw ^{her} him alive on 10/25/60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) C. G. Leibin M.D.				22b. ADDRESS 808 So 15. Blue Springs Mo		22c. DATE SIGNED 10/26/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-28-60	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) K. C., Mo.			
24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar--1800 E. Linwood				25. DATE RECD. BY LOCAL REG. 10-27-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF C. G. Leibin

2025

Dr. F.

leave to
Mary's
the Dr.
sign @

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 James E. Hack

Licensed Embalmer No. 4573

P. O. Address K.C., Mo.

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.