

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042722

LED VS NOV 21 1960

Primary Registration District No. 5687 Registrar's No. 137

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield Twp.</u> Length of stay in 1b <u>35 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Markham Est.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Markham Estate, RFD #1</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANN MARKHAM</u>			4. DATE OF DEATH Month Day Year <u>Nov. 4, 1960</u>				
5. SEX <u>W F</u>	6. COLOR OR RACE <u>W</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>8-3-1916</u>	9. AGE (last birthday) <u>44</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Brookfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jack Woodard</u>			13b. MOTHER'S MAIDEN NAME <u>Captola Mayhugh</u>			14. NAME OF HUSBAND OR WIFE <u>Lawrence E. Markham</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 Address <u>Mrs. Captola Leavitt, Laclede, 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>Respiratory obstruction?</u> DUE TO (b) <u>Smell</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> , , minutes
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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) Hemisphere and brain stem. Old focal hemorrhage left occipital lobe; recent organizing hemorrhage in left frontal lobe. PART III. If deceased was female was there a pregnancy in last 90 days. Yes 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		

21. I attended the deceased from 11-4-60 to 11-4-60 and last saw ^{her} _{him} alive on August, 1960
 Death occurred at 9 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B. D. Howell M.D.</u>		22b. ADDRESS <u>Brookfield Mo.</u>		22c. DATE SIGNED <u>11-15-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 6, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-18-60</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Dep</u>		

MEDICAL CERTIFICATION

NOV 30 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold B. Wright

Licensed Embalmer No. 37

P. O. Address Brookfi

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