

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

-60-046945

Registration District No. 281 Primary Registration District No. 3048 Registrar's No. 2 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nod.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Length of stay in 1b <u>44 days</u>	c. CITY OR TOWN <u>Guilford</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>xx</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Myrtel</u> Middle <u>Brosious</u> Last <u>Brosious</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1960</u>	
--	--	--	--	--

5. SEX <u>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>11.13.88</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Graham, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	---	--	---

13a. FATHER'S NAME <u>Henry Reed</u>	13b. MOTHER'S MAIDEN NAME <u>Ada Thompson</u>	14. NAME OF HUSBAND OR WIFE <u>Harry Brosious</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. <u>unknown</u>	17. INFORMANT <u>Mrs Lester Bledsoe Guilford Mo</u> Address _____
---	---	---

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>Metastatic adenocarcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>of pelvic colon</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 Mos.</u>
---	--	---

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 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 <u>4-28-60</u> to <u>12-31-60</u> and last saw her/him alive on <u>12-31-60</u> Death occurred at <u>10:40 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>W C Bauman MD</u>	22b. ADDRESS <u>1210 Main Maryville Mo</u>	22c. DATE SIGNED <u>1-3-61</u>
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 4, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Parnell Mo.</u>
--	---------------------------------	---	---

24. FUNERAL DIRECTOR <u>Atchison Funeral Home Maryville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-4-61</u>	26. REGISTRAR'S SIGNATURE <u>Beas Holt</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

George M. O'Leary

Licensed Embalmer No. 5114

P. O. Address Marysville

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.