

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009645

STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 147

AMENDED

FILED MAR 21 1961

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINA</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		c. CITY OR TOWN <u>MARCELINE</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>		d. STREET ADDRESS (If outside, give location) <u>108 E. HOWELL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH CHARLES BRESSON</u>			4. DATE OF DEATH Month Day Year <u>MAR 16 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INT. HARVESTER CO</u>		11. BIRTHPLACE (City and state or country) <u>KILLBUCK OHIO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>ARISTIDE BRESSON</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ANN SIMON</u>		14. NAME OF HUSBAND OR WIFE <u>LUCY BRESSON</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>NO</u>		17. INFORMANT Address <u>SISTER EUCHARIA MARCELINE 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>Cerebral Thrombosis, multiple</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>	
	DUE TO (c) _____	

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	
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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 1949 to 3-16-61 and last saw her alive on 3-16-61
Death occurred at 3:10 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert W. Johnson</u>		22b. ADDRESS <u>Marceline, Mo.</u>		22c. DATE SIGNED <u>3-17-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-20-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. COLUMBUS-CEN.</u>	23d. LOCATION (City, town, or county) <u>CONCEPTION Mo.</u>	(State)
24. FUNERAL DIRECTOR ADDRESS <u>MILLER-FILITSON MARCELINE Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-18-61</u>	26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

MAR 28 1961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Libburn K. Ticeatton

Licensed Embalmer No. 4508

P. O. Address Marceline, 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.