MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-014088

STATE FILE NUMBER

AMENDED

Registration District No. 150 Primary Registration District No. 5574 Registrar's No. 32

FILED APR 27 1961

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: VanBuren Twp.
Length of stay in 1b: 89 Yrs.
c. FULL NAME OF HOSPITAL OR INSTITUTION: 2½ Mi. S.W. Lone Jack
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Jackson
c. CITY OR TOWN: Lone Jack
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 150 Highway
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Ruby Middle: May Last: Brain
4. DATE OF DEATH: Month: April Day: 16 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ X
8. DATE OF BIRTH: 1/7/1872
9. AGE (last birthday): 89
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Jackson County Mo.
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Thomas J.Tugker
13b. MOTHER'S MAIDEN NAME: Martha Ann Powell
14. NAME OF HUSBAND OR WIFE: J.W.Brain (dec)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs Lester Church Address: Lone Jack Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bleeding esophageal varices.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan. 4, 1956 to April 16, 1961 and last saw her alive on April 16, 1961
Death occurred at 1:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): C W Ellelund MD
22b. ADDRESS: Pleasant Hill Mo.
22c. DATE SIGNED: 4-16-61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-19-61
23c. NAME OF CEMETERY OR CREMATORY: Lee's Summit
23d. LOCATION (City, town, or county) (State): Lee's Summit Mo.
24. FUNERAL DIRECTOR: Langsford Funeral Home ADDRESS: Lee's Summit Mo.
25. DATE RECD. BY LOCAL REG.: 4-18-1961
26. REGISTRAR'S SIGNATURE: N. B. Langsford

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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_____ Signed M B Langford
Signature of Student Embalmer

Licensed Embalmer No. 3833

P. O. Address Leo Summit 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.