

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3601

FILED APR 24 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Miller	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Eldon	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 402 No. Mill, St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amos Middle Branson Last Branson			4. DATE OF DEATH Month April Day 15 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/26/1897
9. AGE (last birthday) 63		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Rock Island R. R.	11. BIRTHPLACE (City and state or country) Compton Hill, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James Branson	
13b. MOTHER'S MAIDEN NAME Florence Ann Branson		14. NAME OF HUSBAND OR WIFE Rose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 159XF	
17. INFORMANT Donald Martin, Olean, Missouri.		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) Gastrointestinal hemorrhage & shock. CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a) Gastrointestinal neoplasm exact site undetermined. IMMEDIATE CAUSE (b) Pathological fracture of left femur. CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (b) 159XF 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			INTERVAL BETWEEN ONSET AND DEATH 3/12/61 - 4/15/61
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 3/18/61 to 4/15/61 and last saw ^{him} _{him} alive on 4/14/61 Death occurred at 4:50 AM 4/15/61 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James J. Trigg M.D. (Degree or title)		22b. ADDRESS 7820 Carondelet Clayton	
22c. DATE SIGNED 4/15/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-15-61	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) Bell, Mo.	
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. APR 15 1961	
26. REGISTRAR'S SIGNATURE Roan Smith, M.D.			

JUN 16 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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis 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.