

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026452

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 288

FILED AUG 1 1961

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN BONNE TERRE MO.		Length of stay in 1b	c. CITY OR TOWN FARMINGTON
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BONNE TERRE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 203 NELSON
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JAMES BRANON			4. DATE OF DEATH Month Day Year JULY 24 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/22/93	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY MECHANIC	11. BIRTHPLACE (City and state or country) SCOTT COUNTY MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ROBERT BRANON		13b. MOTHER'S MAIDEN NAME KATHERINE GRIFFITH		14. NAME OF HUSBAND OR WIFE AUDIE BLOOM BRANON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS WM. BRANON 203 NELSON	

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>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>"Stroke" c left hemiplegia</u>			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 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 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 July 22, 1961 to July 24, 1961 and last saw her/him alive on July 24, 1961
Death occurred at 3:15 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. A. Huckstep M.D.</u>	22b. ADDRESS <u>301 West Liberty Farmington, Mo.</u>	22c. DATE SIGNED <u>7-25-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/26/61	23c. NAME OF CEMETERY OR CREMATORY CHESTNUT RIDGE
24. FUNERAL DIRECTOR ADDRESS C.H. COZEAN FARMINGTON MO.		23d. LOCATION (City, town, or county) NEAR FARMINGTON MO.

25. DATE RECD. BY LOCAL REG. <u>July 25, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Ethel R. Rudloff</u>
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AUG 14 1961

AUG 2 1961

AUG 18 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 W. Cozear

Licensed Embalmer No. 4084

P. O. Address Farmington, Me.

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.