

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-028341

STATE FILE NUMBER

AMENDED

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **522**

FILED AUG 28 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|--|--|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Boone | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Cole | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia | | Length of stay in 1b 16 days | | c. CITY OR TOWN JEFFERSON, City | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION M.U. Medical Center | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Route 1 | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle L. Last BRONDEL | | | 4. DATE OF DEATH Month 8 Day 22 Year 61 | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-30-95 | 9. AGE (last birthday) 65 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Mfg. | | 10b. KIND OF BUSINESS OR INDUSTRY Ellston, Mo. | | 11. BIRTHPLACE (City and state or country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME FRED BRONDELL | | | 13b. MOTHER'S MAIDEN NAME MARGARET CASPARI | | | 14. NAME OF HUSBAND OR WIFE NONE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NONE | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT medical records, U.M. Medical Center Address Columbia, Mo. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular asystole INTERVAL BETWEEN ONSET AND DEATH immed | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) peripheral vascular collapse 9 hrs | | | | | | | |
| DUE TO (c) status asthmaticus unknown | | | | | | | |
| 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 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 Aug 6 1961 to Aug 22 and last saw her/him alive on Aug 22 1961 Death occurred at 10:45 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) RE Lehman MD | | | | 22b. ADDRESS 11-B Union-Town Columbia Mo | | 22c. DATE SIGNED 8/29/61 | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | |
| burial | | 8/25/61 | St Martin's | | St Martin's Mo. | | |
| 24. FUNERAL DIRECTOR Sylvester Dulle | | | ADDRESS JC Mo. | | 25. DATE RECD. BY LOCAL REG. August 22 1961 | | 26. REGISTRAR'S SIGNATURE Mrs R.E. Palmer |

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 Sylvester D. Smith

Licensed Embalmer No. 4321

P. O. Address Jefferson City, 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.