

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040560
STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Registration District No. 096 Primary Registration District No. _____ Registrar's No. 71

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Buffalo		Length of stay in 1b life	c. CITY OR TOWN Buffalo Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION S. Cedar St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) S. Cedar St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EVERETT Middle N. Last BRUNDRIDGE			4. DATE OF DEATH Month Nov. Day 9 Year 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 July 26, 1891	9. AGE (last birthday) 70	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) service station Op.		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (City and state or country) Dallas		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME George W. Brundridge		13b. MOTHER'S MAIDEN NAME Sarah Garrison		14. NAME OF HUSBAND OR WIFE Vivia Brundridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Vivia Brundridge Buffalo, 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) Gastric hemorrhage			INTERVAL BETWEEN ONSET AND DEATH one hour	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Metastatic carcinoma of the stomach		3 mos.
		DUE TO (c) Adeno-carcinoma of the prostate		8 mos.

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 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 June 6, 1961 to Nov. 4, 1961 and last saw ^{her}him alive on Nov. 4, 1961
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Joseph G. Bennett, D.O.</i> (Degree or title)	22b. ADDRESS Buffalo, Missouri	22c. DATE SIGNED 11/11/61
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Nov. 12, 1961	23c. NAME OF CEMETERY OR CREMATORY Center Point	23d. LOCATION (City, town, or county) Dallas Co. Mo.	(State)
--	-----------------------------------	---	--	---------

24. FUNERAL DIRECTOR L. B. Jones	ADDRESS Buffalo, Mo.	25. DATE RECD. BY LOCAL REG. 12/11/61	26. REGISTRAR'S SIGNATURE <i>Mrs Vera Pitts</i>
--	--------------------------------	---	--

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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 R. E. Chestham

Licensed Embalmer No. 3813

P. O. Address Buffalo, N.Y.

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.