

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018422

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 224

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 11 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>COLE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>TEXAS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u> | | c. CITY OR TOWN <u>SUMMERSVILLE</u> | |
| 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 <u>CHARLES-E-STILLS OSTEOPATHIC</u> | | d. STREET ADDRESS (If outside, give location) <u>MO</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>JAY</u> Middle <u>CHARLES</u> Last <u>BRASHEAR</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1962</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHT</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/21/1894</u> |
| 9. AGE (last birthday) <u>68</u> | | IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (City and state or country) <u>RAYMONDVILLE, MO</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | | 13a. FATHER'S NAME <u>GEORGE BRASHEAR</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>MAGGIE B. MILLER</u> | | 14. NAME OF HUSBAND OR WIFE <u>MARTHA KNACK</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>MARTHA BRASHEAR MISSOURI</u> | | Address <u>SUMMERSVILLE</u> | |
| 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>Sepsis due to Terminal Broncho-pneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombotic encephalomalacia</u> | | | <u>1 wk</u> |
| DUE TO (c) <u>arteriosclerosis</u> | | | <u>chronic</u> |
| 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 <u></u> s.m. <u></u> p.m. <u></u> Month, Day, Year <u></u> | | 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.) <u>May 25 - 1962</u> | | 20f. CITY, TOWN, OR LOCATION <u>Jefferson city mo</u> | |
| 20g. COUNTY <u></u> | | 20h. STATE <u></u> | |
| 21. I attended the deceased from <u>May 25 - 1962</u> , to <u>June 2, 1962</u> and last saw him alive on <u>June 2, 1962</u> Death occurred at <u>2:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>D. Wal Atterbery D.O.</u> | | 22b. ADDRESS <u>Jefferson city mo</u> | 22c. DATE SIGNED <u></u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>6-6-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Durant</u> | 23d. LOCATION (City, town, or county) (State) <u>Durant Iowa</u> |
| 24. FUNERAL DIRECTOR <u>L. F. Evans</u> | | 25. DATE RECD. BY LOCAL REG. <u>9 June 1962</u> | 26. REGISTRAR'S SIGNATURE <u>R. Davis M.D. Richter, Dep.</u> |
| ADDRESS <u>Waverston Mo</u> | | | |

USE BLACK INK OR TYPEWRITER RIBBON

JUL 3 1962

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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 *Edward L. Prang*

Licensed Embalmer No. 4766

P. O. Address *Mtn Grove*

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.