

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048345

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 1

FILED JAN 7 1964

VS 300
Rev. 4/59

1 7005

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in lb <u>4 1/2 mo.</u>	c. CITY OR TOWN <u>Independence</u> 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>SKY View Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>113 West Linden</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>S.</u> Last <u>Brown</u>			4. DATE OF DEATH <u>December 22, 1963</u> Month <u>December</u> Day <u>22</u> Year <u>1963</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1865</u>	9. AGE (last birthday) <u>98</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Samuel Morrison</u>	13b. MOTHER'S MAIDEN NAME <u>Ophelia White</u>	14. NAME OF HUSBAND OR WIFE <u>Edward F. Brown</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>NO</u>)	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Paul E. Nead, Independence, Mo.</u> Address <u> </u>
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18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
DUE TO (b) <u>General Debility</u>		Months <u> </u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u> </u> a.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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>May 12, 1962</u> to <u>Dec. 22, 1963</u> and last saw her alive on <u>Dec. 17, 1963</u> Death occurred at <u>12:30</u> <u>A</u> .m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Walter B. Fouts, M.D.</u> (Degree or title)	22b. ADDRESS <u>10901 Winner Road, Indep., Mo.</u>	22c. DATE SIGNED <u>12/23/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u>	23b. DATE <u>Dec. 26, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Appleton City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Appleton City, Missouri</u>
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24. FUNERAL DIRECTOR <u>Roland R. Speaks, Indep., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-23-63</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Cray</u>
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USE BLACK INK OR TYPEWRITER RIBBON

JAN 23 1964

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1964
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Box 23-63

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 *Richard R. Jenkins*

Licensed Embalmer No. 3604

P. O. Address *Indy, 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.