

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 3 1942

Registration District No. 1

Primary Registration District No. 3012

Registrar's No. 178

24
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mos. 12 days
(Specify whether In this community 1 mos. 12 days
years, months or days)

3. (a) PRINT FULL NAME James E. Brock

3. (b) If veteran, name war World War I

3. (c) Social Security No. 430-12-6193

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Myrtle Brock

6. (c) Age of husband or wife if alive 30 yrs years

7. Birth date of deceased June 19, 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>5</u>	<u>1</u>	hr. _____ min.

9. Birthplace Ashflat, Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation WPA laborer - unemployed

11. Industry or business _____

12. Name Will Brock

13. Birthplace Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Ray Hill

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 11-20-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Vernon, Mo.

18. (a) Signature of funeral director Claude Fritchard, Undertaker

(b) Address Excelsior Springs, Missouri

19. (a) 11-21-42 (b) Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town Mount Vernon
(If outside city or town limits, write "RURAL")

(d) Street No. --
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20th
year 1942 hour 5:02 minute A. M.

21. I hereby certify that I attended the deceased from October 8, 1942, to November 20, 1942, that I last saw him alive on November 20, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic far advanced, active,
with large cavitations, both uppers

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) --

(b) Date of occurrence --

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Forrest G. Bell, M.D. (M.D. or other)
Address Veterans Administration Date signed 11-20-42

MOTHER FATHER

Duration

unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Health Officer No. 8,

Case File Number

Date Filed

12-2-42

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Robert Ray

Licensed Embalmer No.

4182

P. O. Address

Excelsior Springs, 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 this body is not embalmed; fact should be so stated above.