

FILED APR 7 1944

Registration District No. **1**

Primary Registration District No. **3000**

Registrar's No. **81**

1. PLACE OF DEATH:

(a) County **Adair**  
(b) City or town **Kirkville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Laughlin Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 days**  
In this community **10 days**  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME

**Florence Irene Brock**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Lloyd Brock** 6. (c) Age of husband or wife if alive **30** years

7. Birth date of deceased: **January 30 1888**  
(Month) (Day) (Year)

8. AGE: Years **56** Months **1** Days **15** If less than one day  
br. min.

9. Birthplace **Celina Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **Domestic**

12. Name **Warren Gales**

13. Birthplace **Morgan County Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Jane McCain**

15. Birthplace **Jackson County Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Rachel Howell**  
(b) Address **Coldwater, Ohio**

17. (a) **Burial** (b) Date thereof **3/19/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Swamp Cemt. Celina**

18. (a) Signature of funeral director **D. J. Wagner**  
**Kirkville, Mo.**

(b) Address **3/15/44**  
(Date received local registrar)

(c) **D. J. Wagner** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ohio** (b) County **Mercer**  
(c) City or town **Celina**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **RR # 2** (If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **14**  
year **1944** hour **10** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **March 6/44**  
to **March 14/44**  
that I last saw her alive on **March 14/44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronch. pneumonia**

Due to **107**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Toxic Gastric**

Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

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?

While at work? (Specify type of place) (Means of injury)

23. Signature **D. J. Wagner** (M. D. or other)  
Address **Laughlin Hospital** Date signed **3/15/44**

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

2-43  
7-39  
X35697

RECEIVED

District Health Officer No. 10

District File Number 4-44-206

Date Filed APR 6 1944

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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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed A. J. River.....

Licensed Embalmer No. 1407

P. O. Address Winchester, 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.