

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32542

State File No. _____

FILED OCT 17 1946

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 382

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Grim-Smith Hospital & Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Novinger
(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 _____

3. (a) PRINT FULL NAME George Ross Broseghini

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased January 25 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months 7 Days 16
If less than one day hr. _____ min.

9. Birthplace Novinger, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Joe Broseghini

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

14. Maiden name Margaret Lentz

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

16. (a) Informant Mrs. Joe Broseghini

(b) Address Novinger, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46
(Month) (Day) (Year)

(c) Place: burial or cremation Novinger, Missouri

18. (a) Signature of funeral director [Signature]

(b) Address Kirksville, Missouri

19. (a) 10-7-46 (Date received local registrar)

(b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 11
year 1946 hour 5:45 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Sept. 9 1946 to Sept. 11 1946
that I last saw him alive on September 11, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death:
Intestinal perforation with hemorrhage

Due to Colonic diverticulosis

Due to Congenital

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

Duration

4 hours

PHYSICIAN

Major findings:
Of operations _____

Of autopsy 1610

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)

(e) Means of injury _____

23. Signature E. S. Smith MD (M. D. or other)

Address Kirkville Mo Date signed Sept 12/46

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District Health Officer No. 10
10-15-1946

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 *J. E. Kelley*
Licensed Embalmer No. *4181*
P. O. Address *Rockwell Ave*

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.