

No. 2  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 12 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9652**  
Registrar's No. **17**

Registration District No. **273** Primary Registration District No. **5919**

1. PLACE OF DEATH:  
(a) County **PERRY**  
(b) City or town **RURAL SALINE TOWNSHIP**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **NONE** (Specify whether)  
in this community **LIFE** (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MISSOURI** (b) County **PERRY** **79**  
(c) City or town **RURAL** (If outside city or town limits, write "RURAL") **0**  
(d) Street No. **0** (If rural, give location) **0**  
(e) Citizen of foreign country? **NO** (Yes or No) **0**  
If yes, name country

3. (a) PRINT FULL NAME **DIANNA MARIE BRUCKERHOFF**  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex **FEMALE** race **WHITE** 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 **FEB 28 1948**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**4** hr. min.

9. Birthplace **PERRY CO MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **SYLVAN BRUCKERHOFF**  
13. Birthplace **MONTGOMERY CO MO**  
(City, town, or county) (State or foreign country)

14. Maiden name **EDNA HUBER**  
15. Birthplace **CAPE GIRARDEAU CO MO**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Sylvan Bruckerhoff**  
(b) Address **St Mary's No RR 1**

17. (a) **BURIAL** (b) Date thereof **3-3-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **ST MARY'S CH**

18. (a) Signature of funeral director **Res. C. Bask**  
(b) Address **St. Mary's No RR 1**

19. (a) **3-8-48** (b) **Joey Zellmer**  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR** day **3**  
year **1948** hour **9** minute **30 A.M.**  
21. I hereby certify that I attended the deceased from **March 3 1948**  
**FEB-29 1948** to **MARCH 3 1948**  
that I last saw him alive on **MARCH 3 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** ✓  
Duration **2 days**  
Due to  
Due to  
Other conditions: (Include pregnancy within 3 months of death)

Major findings:  
Of operations  
Of autopsy  
PHYSICIAN  
Underline the cause to which death could be charged statistically.  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

22. If death was due to external causes, fill in the requested  
(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 **0 M.D.**  
23. Signature **St. Genevieve No** (M. D. or other) **0 M.D.**  
Address **St. Genevieve No** Date signed **3-4-48**

RECEIVED

Health Officer No. 4

File Number 448-46

Date 4-10-48

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 <sup>NOT</sup>.....

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

Signed Geo. Barber

Licensed Embalmer No. 1985

P. O. Address St. Genevieve 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *April 197*

Registration District No. *273*

Primary Registration District No. *5919*

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Perry*

(b) City or town *Rural*

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *Diana M Bruckhoff*

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* Day *3*

year *1974* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_.

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

4. Sex *F*

5. Color or race *W*

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased *Feb 28*

(Month) (Day) (Year)

*Pneumonia & Bronchial*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) *Mo*

10. Usual occupation \_\_\_\_\_

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)

(c) Means of injury \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

{ 13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

{ 14. Maiden name \_\_\_\_\_

{ 15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

(Date received local registrar)

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

S-9652

At General's mo

Arthur E. Reynolds