

No. 300
-10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

37017

State File No. _____

FILED DEC 6 1948

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 210

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County Emergency Hosp
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 50 yr years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Nickman Mills Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 90 + Prospect
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

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

3. (b) If veteran, No name war _____
3. (c) Social Security No. 495-09-3254

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20th
year 1948 hour one minute 45 a.m.
21. I hereby certify that I attended the deceased from July 1948
1948 to Nov 16, 1948.
that I last saw h. i. M. alive on Nov 16, 1948.
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Brock
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Oct 8 - 1897
(Month) (Day) (Year)

Immediate cause of death cerebral hemorrhage Duration _____
Due to Hypertension

8. AGE: Years Months Days If less than one day
71 1 12 hr. min.

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

9. Birthplace Fort Scott Kan
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

Major findings: Of operations g. n. s. Underline the cause to which death should be charged statistically.
Of autopsy _____

11. Industry or business Care taker of Property

12. Name C. S. Brock

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

14. Maiden name Leola Lawton

15. Birthplace Fort Scott Kan
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mary Brock

(b) Address Nickman Mills Mo

17. (a) Burial (b) Date thereof 11-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lee's Summit

18. (a) Signature of funeral director N. B. Langford

(b) Address LEE'S SUMMIT, MO

19. (a) NOV 22, 1948 (b) Donald C. Embury
(Date received local registrar) (Registrar's signature) 372

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 D. D. Hooper (M. D. or other) _____
Address Brandview, MO Date signed Nov 20, 1948

380 846

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 W. Blangford

Licensed Embalmer No. 3833

P. O. Address Leis Summit Dr

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.