

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 80

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 4024 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Barry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cassville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cassville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Purves Hospital		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Albert b. (Middle) Brock c. (Last) Brock		4. DATE OF DEATH (Month) (Day) (Year) Jan. 17 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 9-4-1885
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mason		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Shell Knob, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Isaac Brock	
13b. MOTHER'S MAIDEN NAME Elizabeth Alderidge		14. NAME OF HUSBAND OR WIFE Lulu Brock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Elaine Duncan		ADDRESS Wheaton, MO.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>apoplexy</i> ANTECEDENT CAUSES <i>Essential Hypertension</i> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 334	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 2			
22. I hereby certify that I attended the deceased from Jan 1, 1949, to Jan 17, 1949, that I last saw the deceased alive on Jan 17, 1949, and that death occurred at 10:45 P. m., from the causes and on the date stated above.			
23a. SIGNATURE E. E. McDaniel (Degree or title) M.D.		23b. ADDRESS Cassville, Mo.	
23c. DATE SIGNED Jan. 21-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-20-1949	
24c. NAME OF CEMETERY OR CREMATORY Horner Cemetery		24d. LOCATION (City, town, or county) Barry County, Missouri (State)	
DATE REC'D BY LOCAL REG. Jan 23-1949		REGISTRAR'S SIGNATURE Grace Williams	
25. FUMERAL DIRECTOR'S SIGNATURE J. E. Ceeber		ADDRESS Cassville	

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

RECEIVED

Detroit Health Officer No. 6,

District No. 149-93

Date Filed 1-29-49

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Margaret Cuker

Licensed Embalmer No. 4389

P. O. Address Cassville

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.