

FILED AUG 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22927

State File No. ....

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

29

|  |  |  |   |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>93</u>   |   | PRIMARY REG. DIST. NO. <u>5344</u>   |  | Registrar's No. <u>64</u>                               |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dade, (N. Morgan Sup)</u>  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission):<br>a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u> |  |   |  |   |  |
| b. CITY OR TOWN <u>Aldrich, Mo. S.W.</u>   |  | c. LENGTH OF STAY (In this place) <u>13 yrs</u>  |   | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Aldrich; N. Morgan Sup</u>                                    |  |   |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7 Miles S. W. of Aldrich</u>  |  |  |   | d. STREET ADDRESS (If rural, give location)<br><u>7 Miles S. W. of Aldrich</u>   |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Catherine</u> b. (Middle) <u>Shields</u> c. (Last) <u>Bruce</u>  |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7-25-1949</u> |  |  |   |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>Wh</u>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>  |  | 8. DATE OF BIRTH <u>July 28 1876</u>                    |  |   |  |
| 9. AGE (In years last birthday) <u>72</u>  |  | 10. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>Glasco Scotland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>            |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>   |  | 13a. FATHER'S NAME <u>George Allen</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>James A. Bruce</u>       |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME <u>James A. Bruce</u> ADDRESS <u>Aldrich Mo</u>  |  |   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                  |  |  |   | MEDICAL CERTIFICATION  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>apoplexia</u>  |  |  |   | DUE TO (b) <u>Hypotension</u>  |  |   |  |   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  |  |  |   | DUE TO (c) <u>-</u>  |  |   |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |   |  |  |   |  | <u>444X</u>   |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |   |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>May 1, 1949</u> , to <u>July 15, 1949</u> , that I last saw the deceased alive on <u>July 23, 1949</u> , and that death occurred at <u>7:25 P.M.</u> , from the causes and on the date stated above. |  |  |   |  |  |   |  |   |  |
| 23a. SIGNATURE <u>B B Kirby M.D.</u> (Degree or title)   |  |  |   | 23b. ADDRESS <u>Dadeville Mo</u>   |  | 23c. DATE SIGNED <u>July 27, 49</u>                     |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 24b. DATE <u>July 27-1949</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Gleason Ridge, S. W. of Aldrich Mo</u>   |  | 24d. LOCATION (City, town, or county) (State) <u>Mo</u> |  |   |  |
| DATE REC'D BY LOCAL REG. <u>8-1-49</u>   |  | REGISTRAR'S SIGNATURE <u>Geo. L. Weir</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. ...</u>  |  | ADDRESS <u>Dadeville Mo</u>                             |  |   |  |

RECEIVED AUG 8 1949  
District Health Office No. 6,  
District File Number 849-912  
Date Filed 8-8-49

AUG 22 1949

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 Willard B. Erwin

Licensed Embalmer No. 3092

P. O. Address Bolivar, 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.