

FILED NOV 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35577

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3068 Registrar's No. 2626

4004

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) Maplewood | | c. CITY (If outside corporate limits, write RURAL and give township) Maplewood | |
| c. LENGTH OF STAY (In this place) 35 Yrs | | d. STREET ADDRESS (If rural, give location) 7912 Caroline | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 7912 Caroline | | | |

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|-------------------------------------|-------------------------|---------------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Sarah | b. (Middle) Hannah | c. (Last) Bruce | 4. DATE OF DEATH (Month) (Day) (Year) Oct 29 1950 |
|-------------------------------------|-------------------------|---------------------------|------------------------|---|

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|-----------------|-------------------------------|---|----------------------------------|---|------------------------|----------------------|----------------------|----------------------|
| 5. SEX F | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 9-9-1866 | 9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HR. Hours | IF UNDER 1 MIN. Min. |
|-----------------|-------------------------------|---|----------------------------------|---|------------------------|----------------------|----------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Steubenville Ohio | 12. CITIZEN OF WHAT COUNTRY? USA |
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|--|--|---|
| 13a. FATHER'S NAME Angus Campbell | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Robert J Bruce |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME Helen B Weiler ADDRESS 7912 Caroline |
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| 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, asphyxia, 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) Cerebral hemorrhage | | 3 hours |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis & hypertension DUE TO (c) _____ | | 10 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | 331X |

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| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|--|

| | | |
|---|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) W | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| | | |
|---|---|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|---|---|----------------------------------|

22. I hereby certify that I attended the deceased from **March 1899** to **Oct 29, 1950**, that I last saw the deceased alive on **Oct 29, 1950**, and that death occurred at **8 A. m.**, from the causes and on the date stated above.

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|---|---|----------------------------------|
| 23a. SIGNATURE (Degree or title) J. M. Brossard M.D. | 23b. ADDRESS 3300 Cambridge Maplewood 17-Mo. | 23c. DATE SIGNED 10/30/50 |
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|---|-----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 10-31-1950 | 24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | 24d. LOCATION (City, town, or county) (State) Kirkwood Mo. |
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| DATE REC'D BY LOCAL REG. 10-30-50 | REGISTRAR'S SIGNATURE Herbert R. Donaldson | 25. FUNERAL DIRECTOR'S SIGNATURE W. Parker ADDRESS Alton Funeral Home, Web Grove, Mo. |
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RWR (Licensed Embalmer's Statement on Reverse Side)

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.....

Leslie Holch

Licensed Embalmer No. *4395*

P. O. Address *Water Grove*

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.