

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6076 State File No. 29041

BIRTH NO. _____ REG. DIST. NO. 27 PRIMARY REG. DIST. NO. 4464 Registrar's No. 3077

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Indiana</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Johns</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brownstown</u>	
c. LENGTH OF STAY (In this place) <u>2 yrs</u>		8130	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Rugh Nursing Home</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Oscar</u> b. (Middle) <u>S.</u> c. (Last) <u>Brooke</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-6-51</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Sept. 6, 1864</u>		9. AGE (In years last birthday) <u>87</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mamie Brooke</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. C. Brooke 449 Calmar Webster</u>	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>331K</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
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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)		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) (Minute)		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 Sept 2, 1951, to Sept 6, 1951, that I last saw the deceased alive on Sept 6, 1951, and that death occurred at 930a m., from the causes and on the date stated above.

23a. SIGNATURE <u>G.W. Knapp</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>498 1/2 Thrush ave</u>		23c. DATE SIGNED <u>9/6/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9-7-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery.</u>	
24d. LOCATION (City, town, or county) (State) <u>Brownstown Ind.</u>					

DATE REC'D BY LOCAL REG. <u>9-6-51</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donke, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Shepard Funeral Home 1167 Hamilton</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *J Wm Bentley* _____

Licensed Embalmer No. *3653* _____

P. O. Address *St Louis. 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.