

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35814**

FILED DEC 7 1955

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **355**

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville	c. LENGTH OF STAY (in this place) 7 days	c. CITY OR TOWN Novinger	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION C. N. H. #1		STREET ADDRESS (If rural, give location) Novinger.	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Brocaille c. (Last) Brocaille			4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1955		
5. SEX FM	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 6, 1877	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Belgium		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Omer Trolard	13b. MOTHER'S MAIDEN NAME Margaret	14. NAME OF HUSBAND OR WIFE Victor Brocaille
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) X	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Raymond Mosley, Novinger, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONITIS		DUE TO (b) SENILITY		7 days
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) ARTERIO SCLEROSIS		2 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. EPILEPSY		492X		

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) m.	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 **March 6, 1955**, to **Nov. 27, 1955**, that I last saw the deceased alive on **Nov. 27, 1955**, and that death occurred at **7:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE R. H. ... (Degree or title)	23b. ADDRESS Kirksville, Mo.	23c. DATE SIGNED 11/29/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/30/55	24c. NAME OF CEMETERY OR CREMATORY Novinger	24d. LOCATION (City, town, or county) (State) Novinger, Mo.
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DATE REC'D BY LOCAL REG. 12-2-55	REGISTRAR'S SIGNATURE Wate. Lamwert	FUNERAL DIRECTOR'S SIGNATURE ... ADDRESS Kirksville, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *George W. Davalt*.....

Licensed Embalmer No. *479*.....

P. O. Address *Russville*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.