

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

33162

State File No.

FILED OCT 29 1956

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1129

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph		c. LENGTH OF STAY (in this place) 19 yr. 2mo. 4 da	c. CITY OR TOWN Oceola
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #2		e. STREET ADDRESS (If rural, give location) 09301	
3. NAME OF DECEASED a. (First) ALIENE		b. (Middle)	c. (Last) BRUCE
4. DATE OF DEATH Oct. 17, 1956		5. SEX female	
6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	
8. DATE OF BIRTH Jan. 12, 1914		9. AGE (In years last birthday) 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Oceola, Mo.--		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Bruce		13b. MOTHER'S MAIDEN NAME Alice Syms	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME George Bruce, Oceola, Mo. ADDRESS	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac standstill ANTECEDENT CAUSES DUE TO (b) thyrotoxicosis chronic Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. cardiac decompensation chronic	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 19 years	
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)	
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>10/1</u> , 19 <u>56</u> , to <u>10/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>56</u> , and that death occurred at <u>8:30 a. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE G.E. Garrison M.D.		23b. ADDRESS State Hosp. #2, St. Joseph, Mo.	
23c. DATE SIGNED 10/17/56		23d. LOCATION (City, town, or county) (State) Oceola, Missouri	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 10/17/1956	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. Oct 23, 1956		REGISTRAR'S SIGNATURE Kathleen M. Allison	
25. FUNERAL DIRECTOR'S SIGNATURE Horton Bowen		ADDRESS St. Joseph, Mo.	

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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.....
Signature of Student Embalmer

Signed *William J. [Signature]*.....

Licensed Embalmer No. 4535.....

P. O. Address 345 10th St.....

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.