

FILED MAR 5 1957

STANDARD CERTIFICATE OF DEATH

State File No. 5204

BIRTH NO. 2351-57 REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Newton	
b. CITY (If outside corporate limits, write RURAL and give township) Joplin		c. LENGTH OF STAY (In this place) 6 hrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Freeman Hospital		e. STREET ADDRESS (If rural, give location) 413 So. Ripley	
3. NAME OF DECEASED (Type or Print) a. (First) Infant		b. (Middle)	
c. (Last) Brock		4. DATE OF DEATH (Month) (Day) (Year) February 2, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Feb. 2, 1957
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Joplin, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Robert L. Brock	
13b. MOTHER'S MAIDEN NAME Lillys A. Carlin		14. NAME OF HUSBAND OR WIFE None	
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. none	
17. INFORMANT'S SIGNATURE OR NAME Robert L. Brock		ADDRESS Neosho, Mo.	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immature - (prematurity 30 wks.) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) severe circumvallate placenta DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 4 hours		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) 7615		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 8:52 AM 2-3, 1957, to 2 P.M. 2-2, 1957, that I last saw the deceased alive on 2-2, 1957, and that death occurred at 1 P.M., from the causes and on the date stated above.			
23a. SIGNATURE John E. Burch, M.D.		23b. ADDRESS 607 Main Joplin	
23c. DATE SIGNED 2-3-57		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2-3-57		24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	
24d. LOCATION (City, town, or county) (State) Neosho, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Clark Funeral Home	
25. ADDRESS Neosho, Mo.		DATE REC'D BY LOCAL REG 2-27-57	
REGISTRAR'S SIGNATURE Dove Merriam			

(Licensed Embalmer's Statement on Reverse Side)

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

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County File Number 57-3-128
Date Filed MAR 4 1957
HEALTH OFFICE

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.....
W. A. Johnston

Licensed Embalmer No. 4770

P. O. Address.....
Opelin

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.