

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

106495

STATE FILE NUMBER

FILED JUN 3 1957

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 48

Health & Welfare  
Public  
Services

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <i>Clay</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Clay</i> ✓						
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Excelsion Springs</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Excelsion Springs</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Excelsion Springs Hospital</i>			Length of stay in 1b <i>16 years</i>		d. STREET ADDRESS (If outside give location) <i>220 East Excelsion</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Claude</i> Middle <i>(N)</i> Last <i>Brockman</i>				4. DATE OF DEATH Month <i>May</i> Day <i>14</i> Year <i>1957</i>						
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 8, 1875</i>		9. AGE (In years last birthday) <i>82</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>6</i> Hours <i></i> Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>General Farming</i>		11. BIRTHPLACE (City and state or country) <i>Cumilton, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James L. Brockman</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Reicher</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>492-18-2434</i>		17. INFORMANT <i>Mrs. Fred Fenton</i> Address <i>Columbia, Mo</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>							INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>			
DUE TO (b) <i>Cerebral hemorrhage</i>							DUE TO (c) <i>331XF</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture - in fracture upper Rt. humerus of 6 hours</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>			
20a. ACCIDENT <input checked="" type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>As a result of cerebral hemorrhage - Pt. fell &amp; fractured in fracture</i>							
20c. TIME OF INJURY Hour <i>?</i> Month <i>?</i> Day <i>?</i> Year <i>?</i>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <i>Excelsion Springs</i>		20f. CITY, TOWN, OR LOCATION <i>Excelsion Springs</i>		COUNTY <i>Clay</i>	STATE <i>Mo</i>
21. I attended the deceased from <i>8-20-56</i> to <i>5-14-57</i> and last saw her/him alive on <i>5/17/57</i> Death occurred at <i>2:55</i> A. M. on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>Dr. Eugene P. Johnson</i>				22b. ADDRESS <i>Excelsion Springs, Mo</i>		22c. DATE SIGNED <i>5/14/57</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>May 15, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Huntsville Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Huntsville, Mo.</i>					
24. FUNERAL DIRECTOR <i>Richmond, Mo. Missouri</i>				25. DATE RECD. BY LOCAL REG. <i>5/20/57</i>		26. REGISTRAR'S SIGNATURE <i>Caroline Hutchings</i>				

(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.....  
Signature of Student Embalmer

Signed *George H. ...*

Licensed Embalmer No. 408

P. O. Address *...*

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.