

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35213

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 354

S. 300
v. 1-57

Color, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Jefferson City</u> <u>026%</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>St. Louis Road</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Angelus DeBroeck</u>				4. DATE OF DEATH Month Day Year <u>November 4, 1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1886</u>		9. AGE (In years last birthday) <u>71</u>	10. UNDER 1 YEAR Months Day Hours Min. <u>2 28</u>	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-- Tweedie Footwear Corporation</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cole Co., Mo.</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Bernard DeBroeck</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Katherine Cortorient</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Keath DeBroeck</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.		17. INFORMANT Address <u>Mrs. Mary DeBroeck Jefferson City, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>symptoms for</u>							5 days	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>153x</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input 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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>10/30/57</u> to <u>11/4/57</u> and last saw her alive on <u>11/4/57</u> . Death occurred at <u>1:15 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Joseph DeBroeck MD</u>				22b. ADDRESS <u>Jefferson City Mo</u>		22c. DATE SIGNED <u>11/6/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 6, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Victor Breacher J. C. Mo 5 Nov. 1957</u>				25. DATE RECD. BY LOCAL REG. <u>5 Nov. 1957</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Norris, M.D. M.A.</u>		

MEDICAL CERTIFICATION

FEB 10 1958

FEB 19 1958

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 *Victor Buesch*

Licensed Embalmer No. *370*

P. O. Address *J E M*

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.