Health, Welfare Public Service

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0860 1

FILED MAY 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015315
STATE FILE NUMBER

Registration District No. 270 Primary Registration District No. 5993 Registrar's No. 31

1. PLACE OF DEATH
a. COUNTY: Putnam
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Medicine twp. Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Home. Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Putnam 0860
c. CITY OR TOWN: Newtown, Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 2½ N.W. Newtown Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Daniel Middle: Everett Last: Bruce.

4. DATE OF DEATH: Month: April Day: 27 Year: 1958.

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 7 1891
9. AGE (In years last birthday): 67 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Unionville, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank M. Bruce
14. MOTHER'S MAIDEN NAME: Margarette Wymore

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.: 485-10-8821
17. INFORMANT (Address): Mrs. Lenna Bruce, Newtown, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Astrocytoma of dura of brain — 3 yrs.
DUE TO (c) 1930
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Mar. 5, 58 to Apr. 27, 58 and last saw him alive on Apr. 26, 58.
Death occurred at 3:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. Dale (Degree or title) DO.
22b. ADDRESS: Newtown Mo.
22c. DATE SIGNED: 4/28/58

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: Apr. 28, 1958
23c. NAME OF CEMETERY OR CREMATORY: Newtown Cemetery
23d. LOCATION (City, town, or county) (State): Newtown, Mo. Mo.

24. FUNERAL DIRECTOR: Judd & Payne, ADDRESS: Newtown, Mo.
25. DATE RECD. BY LOCAL REG.: 5-10-58
26. REGISTRAR'S SIGNATURE: Merell Durbin

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed T. Howard Judd

Licensed Embalmer No 32

P. O. Address New Ta

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.