

FILED AUG 1 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024711

STATE FILE NUMBER

XC-124 83 61

REG.# 16729

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 476

S. 300

1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ORAN</b> <span style="float: right;">10000</span>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>		Length of stay in lb <b>15 DAYS</b>	d. STREET ADDRESS <b>NONE</b> (If outside, give location)
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS MARTIN BROCKETT</b>			4. DATE OF DEATH <b>JULY 19, 1958</b> Month Day Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-92</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>BARBER</b>	9. AGE (In years last birthday) <b>66</b> 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) <b>BARBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BARBER</b>	11. BIRTHPLACE (City and state or country) <b>McCLEANSBORO, ILLINOIS</b>
13a. FATHER'S NAME <del>UNKNOWN</del> <b>ELSWORTH BROCKETT</b>		13b. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> <b>EASPER BRADEN</b>	14. NAME OF HUSBAND OR WIFE <b>NONA BROCKETT</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>497055464</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS.</b>			UNKNOWN.
DUE TO (c) <b>332X</b>			
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 <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from <b>July 4, 1958</b> to <b>July 19, 1958</b> Death occurred at <b>8:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert S. Cohen</b> (Degree or title) <b>ROBERT S. COHEN, M.D., Chief, Med. Svc.</b>		22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	
22c. DATE SIGNED <b>7-21-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 22 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forrest Hills Memorial</b>	23d. LOCATION (City, town, or county) (State) <b>Morley Mo.</b>
24. EMBALMER DIRECTOR ADDRESS <b>Oran, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7/26/58</b>	26. REGISTRAR'S SIGNATURE <i>R. Mueller</i>

1900

DATE

TIME

1954

STATE OF MISSISSIPPI

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

HEALTH

DEPARTMENT

BY

DATE

X

TIME

DATE

STATE OF MISSISSIPPI

AUG 19 1958

DATE

STATE OF MISSISSIPPI

HEALTH

DEPARTMENT

DEPARTMENT

STATE OF MISSISSIPPI

HEALTH

DATE

DATE

STATE

DEPARTMENT OF HEALTH

STATE

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 \_\_\_\_\_



STATE OF MISSISSIPPI Licensed Embalmer No. 7676

P. O. Address Ocean, Mo

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.