

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028639

STATE FILE NUMBER

FILED AUG 18 1958

Registration District No. 82

Primary Registration District No. 5323

Registrar's No. 13-1958

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

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Knobview</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Cuba</u> <u>290</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT Home on HWY KK</u> Length of stay in lb <u>4 Years</u>		d. STREET ADDRESS (If outside, give location) <u>Route # 2</u> Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Valentine</u> Last <u>Bruecker</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1958</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>Nov. 1 1909</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>48</u> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) <u>ST. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>John Bruecker</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA BRICK</u>	14. NAME OF HUSBAND OR WIFE <u>Belle Gladden</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. <u>492-10-7171</u>	17. INFORMANT Address <u>RT. # 2</u> <u>Mrs Belle Bruecker Cuba, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>SECONDS</u> <u>YEARS</u>
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 _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>4-10-58</u> to <u>8-11-58</u> and last saw <u>him</u> alive on <u>6-8-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>CUBA-MISSOURI</u>	22c. DATE SIGNED <u>8-12-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 13-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kinder</u>
23d. LOCATION (City, town, or county) (State) <u>Cuba</u> <u>MO.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Norman C. [Signature] Cuba, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>8-12-1958</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

AUG 18 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 *Norman E. Hoene*

Licensed Embalmer No. *4623*

P. O. Address *Cuba, 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.