

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039249
STATE FILE NUMBER

FILED DEC 8 1958 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>EXCELSIOR SPRINGS</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>511 GRAND</u>		Length of stay in 1b <u>8 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>6002 511 GRAND</u> o
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>ALLEN</u> Last <u>BROMAGEN</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>9</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>FEB 26, 1923</u>	9. AGE (In years last birthday) <u>35</u> 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) <u>LINEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO POWER + LIGHT</u>	11. BIRTHPLACE (City and state or country) <u>INDIANAPOLIS, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>FRANK BROMAGEN</u>		13b. MOTHER'S MAIDEN NAME <u>VIOLET FULTZ</u>		14. NAME OF HUSBAND OR WIFE <u>DOROTHY RHODES</u>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u>	16. SOCIAL SECURITY NO. <u>306-24-6446</u>	17. INFORMANT <u>MRS DOROTHY BROMAGEN</u> Address <u>SPRINGS, 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) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
DUE TO (b) <u>Hypertension</u>		<u>2 yrs</u>
DUE TO (c) _____		
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? <u>4201</u> 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 _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <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 9-25-53 to 11-9-58 and last saw ^{her} him alive on 11-8-58
Death occurred at 5:45 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>George E. Anderson M.D.</u>	22b. ADDRESS <u>Excelsior Springs, Mo</u>	22c. DATE SIGNED <u>11-10-58</u>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-11-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIDGE PARK</u>	23d. LOCATION (City, town, or country) (State) <u>MARSHALL, MISSOURI</u>
--	------------------------------	---	---

24. NAME AND ADDRESS OF FUNERAL HOME <u>Richard Funeral Home, Inc. Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>11/30/58</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>
---	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEC 8 1958

DEC 6 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 *Ralph Van Landingham*

Licensed Embalmer No. *4009*

Epstein Springs, Inc

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.

DEC 11 1958