

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012341

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 373

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2018 N. Hiway, 275</b>		d. STREET ADDRESS (If outside, give location) <b>5018 N. Hiway, 275</b>	
Length of stay in lb <b>40 years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle Last <b>BROCE</b>			4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1872</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Missouri, Andrew County</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Broce</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Bowman</b>		14. NAME OF HUSBAND OR WIFE <b>Rosa Broce, (deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Frank Schmutzler, St. Joseph, Mo.</b> Address <b>R.F.D. #3</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>Asphyxiation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>at once</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Inhalation of motor exhaust gas, Voluntary</b>			
DUE TO (c) <b>9731</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Man had connected pipe from exhaust on his car into trunk of car</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>(see line above)</b>
20c. TIME OF INJURY <b>9:30 a.m.</b>	Month, Day, Year <b>4/11/59</b>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>at home</b>	20f. CITY, TOWN, OR LOCATION <b>St. Joseph Buchanan Missouri</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at **9:30A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W. S. E. McInerney, M.D.</b>	(Degree or title) <b>Buchanan, Mo.</b>	22b. ADDRESS <b>214 Kurtz Street, Bldg. 8, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>4-11-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April, 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
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24. FUNERAL DIRECTOR <b>Stamen Funeral Home (G.A.S.)</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>April 13, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Standell</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Dr. S. E. McInerney  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Charles E. Bennett* .....

Licensed Embalmer No. *4677* .....

P. O. Address *St. Joseph 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.