

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016772

STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 520

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) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR MISSOURI METHODIST INSTITUTION		Length of stay in lb <b>3 years</b>	d. STREET ADDRESS (If outside, give location) <b>102 N. 2nd St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>BROOKS</b> Last <b>BROOKS</b>			4. DATE OF DEATH Month <b>May</b> Day <b>14</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 type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1908</b>		9. AGE (In years last birthday) <b>50</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>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City market</b>	11. BIRTHPLACE (City and state or country) <b>Troy, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Thomas Brooks</b>		13b. MOTHER'S MAIDEN NAME <b>Josie Sharp</b>		14. NAME OF HUSBAND OR WIFE <b>unknown</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>491-10-1846</b>	17. INFORMANT <b>Mrs. Pauline Burnham, 1002 Dewey, St. Joseph, Mo</b>	
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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>Acute Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		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 _____ a.m. _____ p.m. _____		

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 <b>St. Joseph</b>	COUNTY <b>Buchanan</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>1/14/57</b> to <b>5/14/59</b> and last saw <del>her</del> <sup>him</sup> alive on <b>5/14/59</b> Death occurred at <b>1:30</b> P m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Dr. Owen W. D. Craig</i> (Degree or title)		22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>		22c. DATE SIGNED <b>5/15/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5/16/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Public Cem.</b>	23d. LOCATION (City, town, or county) <b>St. Joseph</b>	(State) <b>Mo.</b>
24. FUNERAL DIRECTOR <b>Heater - Bouman</b>		ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 18, 1959</b>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clara Goodell</i>

All diseases in Part I must be causally related.  
 Dr. Owen W. D. Craig  
 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 *William Spelling*

Licensed Embalmer No. *4535*

P. O. Address *Joseph*

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.