

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029778

FILED VS SEP 11 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 267

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		c. CITY OR TOWN <u>Louisiana</u>	
Length of stay in 1b <u>6 W.</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>St. Elizabeth Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Road # 2</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>AGUSTUS</u> Middle <u>A</u> Last <u>BRUCH</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</u> Year <u>1959</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>9/8/1877</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Pike Co Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Jacob Bruch</u>		13b. MOTHER'S MAIDEN NAME <u>Carolin Schwend</u>	
14. NAME OF HUSBAND OR WIFE <u>Lena Bruch</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Oliver Bruch</u> Address <u>Louisiana Mo.</u>	
16. SOCIAL SECURITY NO. <u>489-42-2276</u>		17. INFORMANT <u>Oliver Bruch</u>		Address <u>Louisiana Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Imaciation</u>			<u>5 months</u>
DUE TO (b) <u>Metastatic carcinoma</u>			<u>18 months</u>
DUE TO (c) <u>Carcinoma of paratoid gland</u>			<u>18 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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. 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.)
20f. CITY, TOWN, OR LOCATION		COUNTY STATE

21. I attended the deceased from July 20, 1959 to August 29, 1959 last saw him alive on August 29, 1959
Death occurred at 3:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John Condit M.D.</u>		22b. ADDRESS <u>M. D. 707 Bdwy, Hannibal, Missouri</u>		22c. DATE SIGNED <u>8-31-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/31/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wain View</u>	23d. LOCATION (City, town, or county) (State) <u>Louisiana Mo.</u>	
24. FUNERAL DIRECTOR <u>Stemmer Funeral Home, Louisiana Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9/3/59</u>	26. REGISTRAR'S SIGNATURE <u>W. M. Lucke By J. C. Fisher</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. B. Sterne

Licensed Embalmer No. *4039*

P. O. Address *Louisiana*

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.