

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026164

FILED VS JUL 18 1960

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 69

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		Length of stay in 1b <u>12 yrs.</u>	c. CITY OR TOWN <u>Carrollton</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>Atwood Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>304 W. Benton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>E. M.</u> Last <u>BROCKMEIER</u>			4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-21-1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Carroll Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>August Berning</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Vogt</u>		14. NAME OF HUSBAND OR WIFE <u>Miss Minnie Berning, Carrollton Mo</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>487-03-1652</u>		17. INFORMANT Address <u>Miss Minnie Berning, Carrollton 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>Cerebrovascular Accident</u>		<u>36 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Severe Cerebral Arteriosclerosis -</u>	<u>unknown</u>
	DUE TO (c) <u></u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>	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
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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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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 Sept 1959 to July 1960 and last saw him alive on 12 July 1960
Death occurred at 7:00 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John L. Jernard MD</u>	22b. ADDRESS <u>Carrollton, Mo</u>	22c. DATE SIGNED <u>7-15-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Near Norborne Mo.</u>
24. FUNERAL DIRECTOR <u>Libson Funeral Home, Carrollton Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-15-60</u>	26. REGISTRAR'S SIGNATURE <u>Miss Leckie Jernard</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 16 1980

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.