

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-60-037809

FILED VS OCT 19 1960

STATE FILE NUMBER

ENDED

Registration District No. 73 Primary Registration District No. 5300 Registrar's No. 112

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CLINTON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Blatt Township</u> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u> c. CITY OR TOWN <u>Blatt Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>LOREN BROCKMAN</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Oct. 7. 1960</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-20-1874</u>	<b>9. AGE (last birthday)</b> <u>86</u>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMING</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>KENTUCKY</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA.</u>		<b>13a. FATHER'S NAME</b> <u>Brockman</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Deceased</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> Address <u>MRS. DIK WALKS CAMERON MO</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Soulity</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) 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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY STATE</b>	
<b>21. I attended the deceased from</b> <u>10/3/60</u> to <u>10/7/60</u> and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>E. Drury M.D.</u>			<b>22b. ADDRESS</b> <u>Stewartville Mo</u>		<b>22c. DATE SIGNED</b> <u>10/8/60</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>10-9-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Grace Land Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>CAMERON MO</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>DeMoss CRWAY CAMERON MO</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Oct 10 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Francis D Crawford</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

*James C. Cunniff*

Licensed Embalmer No. 2837

P. O. Address Common.

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.