SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-009650

STATE FILE NUMBER

AMENDED

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 44

FILED APR 3 1961

1. PLACE OF DEATH
a. COUNTY Linn
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield — Length of stay in 1b 15 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 523 East Prairie — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Linn
c. CITY OR TOWN Brookfield — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 523 East Prairie — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Middle Last: Bessie Lou Cross

4. DATE OF DEATH Month Day Year: March 27, 1961

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 3/23/1883
9. AGE (last birthday): 78 — IF UNDER 1 YEAR Months 0 Days 4 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: in own home
11. BIRTHPLACE (City and state or country): Callao, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: John Malone
13b. MOTHER'S MAIDEN NAME: Sarah Marshall
14. NAME OF HUSBAND OR WIFE: Luther Cross (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: W. S. Cross, Brookfield, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: D.O.A.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 2 year
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Congestive heart failure
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ —
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. Month, Day, Year —
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1-10-61 to 3-27-61 and last saw her/him alive on 3-27-61
Death occurred at 2:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. W. Bohnert M.D.
22b. ADDRESS: Brookfield Mo
22c. DATE SIGNED: 3/28/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: March 30, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Brookfield, Missouri

24. FUNERAL DIRECTOR ADDRESS: Hill Funeral Home, Brookfield, Mo.
25. DATE RECD. BY LOCAL REG.: 3-31-61
26. REGISTRAR'S SIGNATURE: Katharine Johnson Dep

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT | 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 Gerald I Wade

Licensed Embalmer No. 4172

P. O. Address Browning

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.