

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-037475

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 344

FILED NOV 13 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in 1b	c. CITY OR TOWN <u>Kirksville</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.O.H</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD # 4</u>
3. NAME OF DECEASED (Type or print) First <u>Caltha</u> Middle <u>Jane</u> Last <u>Bruner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/84</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	11. BIRTHPLACE (City and state or country) <u>Adair County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Charles Smoyer</u>	
13b. MOTHER'S MAIDEN NAME <u>Marietta Russell</u>		14. NAME OF HUSBAND OR WIFE <u>Charles J. Bruner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Adolfus Hotel</u>		17. INFORMANT <u>Gladys Smoyer- Dallas, Texas</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Decompensated Hypertensive Heart Disease</u>			
DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rt. Hip Fracture October, 1962, Exsanguinating Peptic ulcer</u>			PART III. If deceased was female there a pregnancy in last 90 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk
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 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 <u>10-9-62</u> to <u>11-7-62</u> and last saw her <u>alive</u> on <u>11-9-62</u> Death occurred at <u>12:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James F. Kipe</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>500 W. Jefferson, Kirksville, Mo.</u>	22c. DATE SIGNED <u>11-7-62</u>
23b. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>	23c. DATE <u>11/11/62</u>	23d. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cemetery</u>	23e. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>
24. FUNERAL DIRECTOR <u>Davis & Davis</u> ADDRESS <u>Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-9-1962</u>	26. REGISTRAR'S SIGNATURE <u>Dore W. Galiff</u>

USE BLACK INK OR TYPEWRITER RIBBON

No permit issued

JAMES F. GIBB, D.D.

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville, Mo.

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.