

FILED JUN 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16961

State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>305P</u>		Registrar's No. <u>108</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>St Charles</u>		b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St Charles</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY (in this place) <u>3 da</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Minersville</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Minersville</u>		d. STREET ADDRESS (If rural, give location) <u>None</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>FLETA</u>			b. (Middle) <u>MARIE</u>			c. (Last) <u>BRUCE</u>	
(Type or Print)			4. DATE OF DEATH (Month) (Day) (Year) <u>5-20-1949</u>			5. SEX <u>F</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>6-15-1899</u>		9. AGE (In years last birthday) <u>49</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Wellsville MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>E.W. OSBORN</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Alderson</u>			14. NAME OF HUSBAND OR WIFE <u>Russell Bruce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>W</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Russell Bruce</u>		
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u>			<u>4 days</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			?
				DUE TO (b) <u>Generalized arteriosclerosis</u>			?
				DUE TO (c) <u>Essential Hypertension</u>			<u>? 23</u>
				II. OTHER SIGNIFICANT CONDITIONS			<u>3 mo</u>
				Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Myelitis</u>			
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>no</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>5/2</u> , 19 <u>48</u> , to <u>5/20</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>49</u> and that death occurred at <u>10:15</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Ralph O. Hayden M.D.</u>				23b. ADDRESS <u>St Charles Mo.</u>		23c. DATE SIGNED <u>5/21/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-22-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville</u>		24d. LOCATION (City, town, or county) (State) <u>Wellsville MO</u>	
DATE REC'D BY LOCAL REG. <u>5/24/49</u>		REGISTRAR'S SIGNATURE <u>Fannie Flannery</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Curt Hopkins</u>		ADDRESS <u>Montgomery MO</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed JUN 1 1949

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 on the

20th day of May 1949,

Student Embalmer No. _____

working under my personal supervision.

Signed _____

C. Stephens

Signed _____

Student Embalmer

Licensed Embalmer No. 1489

P. O. Address Waukegan, Ill.

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 this body is not embalmed, fact should be so stated above.