

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37067

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5550 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Howell</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Howell</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location) <u>R.D.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED a. (First) <u>Wilford</u> b. (Middle) <u>Kawelin</u> c. (Last) <u>M^c Broom</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-30-49</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W-</u>	8. DATE OF BIRTH <u>10/2-1869</u>	9. AGE (In years last birthday) <u>79</u>	if UNDER 1 YEAR Months <u>11</u> Days <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thos M^c Broom</u>			
13b. MOTHER'S MAIDEN NAME <u>Hannah Rachel</u>		14. NAME OF HUSBAND OR WIFE <u>Frank</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) _____	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr C. H. Teleman</u>		ADDRESS <u>Howell Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastric Ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gastritis, chron-</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>myocarditis chron- Prostatitis, chron-</u>		<u>2</u>

19a. DATE OF OPERATION <u>not</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>neither</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>5470</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>✓</u>

22. I hereby certify that I attended the deceased from 12/9/49 to 1/30/49, that I last saw the deceased alive on 1/30/49, 1949, and that death occurred at 1:30 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Asst. Rembering, M.D.</u>	(Degree of title)	23b. ADDRESS <u>West Plains, Mo</u>	23c. DATE SIGNED <u>10/9/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>R-</u>	24b. DATE <u>10-2-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shelburne Ia.</u>	24d. LOCATION (City, town, or county) (State) <u>Shelburne Iowa</u>
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DATE REC'D BY LOCAL REG. <u>11-23-49</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robertson</u>	ADDRESS <u>West Plains, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 11/30/49
District Health Officer No. 5,
District File Number 1249740
Date Filed 12/2/49

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____

D. D. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains

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.