

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41723

FILED JAN 14 1950

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

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>455</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (in this place) <u>4 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Palmyra Mo.</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>217 S. 10th. St.</u>				d. STREET ADDRESS (If rural, give location) <u></u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Phillip</u>		b. (Middle) <u>Albert</u>		c. (Last) <u>Bross</u>	
4. DATE OF DEATH		(Month) <u>Dec.</u>		(Day) <u>12</u>		(Year) <u>1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 11 1880</u>		9. AGE (In years last birthday) <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Monroe Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph B. Bross</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Baxter</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Bross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-05-7084</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. E. G. Shinn 217 S. 10 Hannibal Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio-sclerotic Vascular Disease</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 yrs</u>	
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</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>✓</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <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 <u>Sept 10</u> , 19 <u>49</u> , to <u>Dec 11</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>49</u> , and that death occurred at <u>7 a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert J. Flannery MD</u>				23b. ADDRESS <u>570 Bx 1362 Hannibal, Mo</u>		23c. DATE SIGNED <u>12/29/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/14/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Palmyra Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-31-49</u>		REGISTRAR'S SIGNATURE <u>E. J. Shinn</u>		FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Shinn</u>		ADDRESS <u>Palmyra Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED JAN 10 1950
MARION CO. HEALTH DEPT.
DATE FILED JAN 12 1950

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.

Signed E. J. Sprague

Signed.....
Student Embalmer

Licensed Embalmer No. 3245

P. O. Address Palmyra 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 this body is not embalmed, fact should be so stated above.