

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5212**

BIRTH NO. _____ REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **3015** Registrar's No. **11**

0-51

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

1. PLACE OF DEATH a. COUNTY CLINTON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CALDWELL	
b. CITY (If outside corporate limits, write RURAL and give township) CAMERON		c. CITY (If outside corporate limits, write RURAL and give township) RURAL, KIADER, TOWNSHIP	
c. LENGTH OF STAY (In this place) 2 wks.		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION CAMERON HOSPT.			

3. NAME OF DECEASED (Type or Print) Nancy B Brockman.	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) FEB. 8. 1953.
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 21. 1873	9. AGE (In years last birthday) Months Days 79
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) CLINTON MO	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME Thomas Dixon	13b. MOTHER'S MAIDEN NAME Elizabeth Willoughy	14. NAME OF HUSBAND OR WIFE Loren Brockman.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. LORNA WEAS CAMERON, MO
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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		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) interrenal obstruction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) irreparable hernia DUE TO (c) cardiac decompensation limited		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **5-17, 1950** to **2-8-53**, that I last saw the deceased alive on **2-8-53, 19**, and that death occurred at **6:25 PM** from the causes and on the date stated above.

23a. SIGNATURE R E Willbur MD (Degree or title)	23b. ADDRESS Camden MO	23c. DATE SIGNED 2-10-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2-11-1953	24c. NAME OF CEMETERY OR CREMATORY GRACELAND	24d. LOCATION (City, town, or county) (State) CAMERON MO
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DATE REC'D BY LOCAL REG. 2-16-53	REGISTRAR'S SIGNATURE Wm. Fred W. Moser	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joe MOSS CRUNK CAMERON, MO
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(Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed

L. M. Crank

Licensed Embalmer No. *2533*

P. O. Address *Cameron, 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.