

FILED SEP 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 33

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

1. PLACE OF DEATH a. COUNTY <u>HGWELL</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) OR TOWN <u>WEST PLAINS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEST PLAINS</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>STOLL SURG. HOSP</u>		d. STREET ADDRESS (If rural, give location) <u>RTE. 3</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>Ray</u> c. (Last) <u>Broyles</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8-22-54</u>		
---	--	--	---	--	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>5-15-</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
-----------------	---------------------------	---	-------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER, RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (State or foreign country) <u>TMOMPSONVILLE, IDL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
--	--	--	--	--	--	---	--

13a. FATHER'S NAME <u>WM. BROYLES</u>		13b. MOTHER'S MAIDEN NAME <u>CYNTHIA CHAPLAIN</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>	
---------------------------------------	--	---	--	--------------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JOE BROYLES, PEACDE VALLEY, MO</u>	
---	--	----------------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Primary Anemia</u> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <u>?</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			INTERVAL BETWEEN ONSET AND DEATH <u>6 m</u>
---	--	--	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>293 X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	---	--	--	--

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)	
--	--	--	--	---	--

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?	
---	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from Nov 10, 1953 to 8-22, 1954, that I last saw the deceased alive on 8-22, 1954, and that death occurred at 2 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>G B Stoll M.D.</u>		23b. ADDRESS <u>West Plains</u>		23c. DATE SIGNED <u>8/30/54</u>	
--	--	---------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>8-25-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>EPPS</u>		24d. LOCATION (City, town, or county) (State) <u>POMONA, MO.</u>	
--	--	--------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. <u>9-13-54</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERTSONS, WEST PLAINS, MO</u>	
---	--	--	--	---	--



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 _____

Licensed Embalmer No. 3437

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.