

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12860**

BIRTH NO. _____ REG. DIST. NO. 275 PRIMARY REG. DIST. NO. 3053 Registrar's No. 74

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1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Osage	
b. CITY OR TOWN Rolla		c. CITY OR TOWN Meta	
c. LENGTH OF STAY (in this place) 2 1/2 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION McFarland Nursing Home		e. STREET ADDRESS (If rural, give location) 0760 1	

3. NAME OF DECEASED (Type or Print) August Brockwinkle			4. DATE OF DEATH pr. 15, 1955		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married	8. DATE OF BIRTH 3/5/1899	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 10 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Thomas Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Brockwinkle	13b. MOTHER'S MAIDEN NAME Mary Duebbert	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Angela Walthers	ADDRESS St. Thomas, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Several hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	ANTECEDENT CAUSES: Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) the myocarditis.		
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 4/20/55	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) m.	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 3-2-1957 to 4-15, 1957; that I last saw the deceased alive on ?, 19?, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE E.E. Feind M.D.	23b. ADDRESS Rolla Mo.	23c. DATE SIGNED 4-20-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/18/55	24c. NAME OF CEMETERY OR CREMATORY St. Thomas	24d. LOCATION (City, town, or county) (State) St. Thomas Mo.
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DATE REC'D BY LOCAL REG. Apr 20 1955	REGISTRAR'S SIGNATURE Nadine L. Stoll	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Iberia, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Signature of Student Embalmer

Signed *Walter P. Hedges*

Licensed Embalmer No. *426*
P. O. Address *Peris, 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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.