

BIRTH NO. **37837-55** REG. DIST. NO. **290** PRIMARY REG. DIST. NO. **5985** Registrar's No. **76**

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fort Leonard Wood		c. CITY OR TOWN Fort Leonard Wood	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION US Army Hospital		e. STREET ADDRESS (If rural, give location) US Army Hospital	

3. NAME OF DECEASED (Type or Print)	a. (First) Michael Bruce	b. (Middle) Mac Donald	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) June 29 1955
-------------------------------------	---------------------------------	-------------------------------	-----------	---

5. SEX Male	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH 29 June 1955	9. AGE (In years last birthday) 0 Months 15 Days	IF UNDER 1 YEAR 0 Hours 15 Min.
--------------------	---------------------------	--	--------------------------------------	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) US Army Hospital, Ft. Wood, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	---	---

13a. FATHER'S NAME Frank H. Mac Donald	13b. MOTHER'S MAIDEN NAME Mary Louise Ruhaak	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME C. S. Milligan, M.S.C. ADDRESS US Army Hospital, Ft. Leonard Wood, Mo.
--	-------------------------	--

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia due to Fetal Atelectasis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Developmental aberration DUE TO (c) 7620		
II. OTHER SIGNIFICANT CONDITIONS Congestion and edema of all organs Frank Breech. Incomplete dilatation of cervix.			

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

21a. ACCIDENT (Specify) SUICIDE HOMICIDE	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 **June 29, 1955, to June 29, 1955**, that I last saw the deceased alive on **June 29, 1955**, and that death occurred at **5:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE David Griffin, Captain (Degree or title)	23b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri	23c. DATE SIGNED June 29, 55
--	--	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 1 55	24c. NAME OF CEMETERY OR CREMATORY Crocker Memorial	24d. LOCATION (City, town, or county) (State) Crocker Missouri
---	----------------------------	--	---

DATE REC'D BY LOCAL REG. 7-1-55	REGISTRAR'S SIGNATURE Chula Spivey Anderson	25. FUNERAL DIRECTOR'S SIGNATURE 458 ADDRESS HEDGES FUNERAL HOMES INC CROCKER MO
--	--	--

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

File Number 7-2-55
Date Filed 7-2-55

Pulaski County Health Officer

RECEIVED 7-1-55

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 *Clara Grace*

Licensed Embalmer No. 489

P. O. Address *Waynesville*

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.