

FILED NOV 19 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39748

9228

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>MADISON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) <u>2 WKS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FREDERICKTOWN</u>		d. STREET ADDRESS (If rural, give location) <u>210 THOST ST.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DE PAUL HOSPITAL</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BONNIE</u> b. (Middle) <u>STOCKING</u> c. (Last) <u>ROOD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 8, 1956</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED—(Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG-22, 1904</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>DIRK, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ROYAL STOCKING</u>		13b. MOTHER'S MAIDEN NAME <u>ALICE WHITE</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN ROOD</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>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JOHN ROOD - FREDERICKTOWN, 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tumor of the brain</u> INTERVAL BETWEEN ONSET AND DEATH <u>approximately 6 months</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>← 193x</u>			
19a. DATE OF OPERATION <u>7-30-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Tumor of the brain</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 <u>10-28-54</u> , 19____, to <u>10-8-56</u> , 19____, that I last saw the deceased alive on <u>10-8-56</u> , 19____, and that death occurred at <u>9:40 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>F.R. Finnegan M.D.</u>				23b. ADDRESS <u>539 N. Grand Blvd. St. Louis</u>		23c. DATE SIGNED <u>10-9-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10/11/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CHARLESTON CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>MISSISSIPPI CO. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>OCT 9 1956</u>		REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>		25. EMBALMER'S SIGNATURE ADDRESS <u>W. A. Addison - FREDERICKTOWN, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Entrusted to the Missouri State Health Department

1/11/11
1/11/11
1/11/11

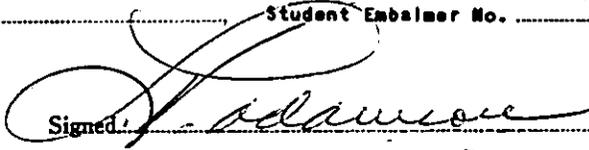
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

.....
working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed: 

Licensed Embalmer No. 4357

P. O. Address FREDERICKTOWN, MD

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.