

FILED OCT 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38914**

BIRTH NO. _____ REG. DIST. NO. 356 PRIMARY REG. DIST. NO. 4521 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Houston, Mo.</u>)	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Houston</u>	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 <u>McKeaney Rest Home</u>		e. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Le</u> b. (Middle) <u>W.</u> c. (Last) <u>Bruce</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 6 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>4-14-1873</u>
9. AGE (In years last birthday) <u>84</u>		10. UNDER 1 YEAR Months <u>0</u> Days <u>22</u>	11. UNDER 18 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, average if several)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>West Union Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Sam Bruce</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha</u>		14. NAME OF HUSBAND OR WIFE <u>James Earl Bruce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>505-05852</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Floyd Knight</u>		ADDRESS <u>H. O. MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MANY YEARS</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity 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>CHRONIC BRONCHITIS</u>		<u>2</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</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) (Min.)		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>10-8</u> , 19 <u>56</u> , to <u>MAY 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>57</u> , and that death occurred at <u>3 a.m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>John M. Tam M.D.</u>		23b. ADDRESS <u>Houston, Mo.</u>	
23c. DATE SIGNED <u>10/6/57</u>		24a. PORTAL, CREMATION, REMOVAL (Specify)	
24b. DATE <u>5-8-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	
24d. LOCATION (City, town, or county) (State) <u>Santa Rosa, Mo.</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>Leah D. Smith</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 18-57</u>		REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>	
25. GENERAL DIRECTOR'S ADDRESS <u>Missouri Gov. MO.</u>			

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

327

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.....
Frank Gable

Licensed Embalmer No. *440*

P. O. Address *Wm. Gable*

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.

A