Health, Welfare Public Service 70 300 1 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000535

STATE FILE NUMBER

FILED JAN 12 1958 Registration District No. 57 Primary Registration District No. Registrar's No. 1

1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Eugene Tomwship — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Wakenda RFD #1 — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Carroll
c. CITY OR TOWN "Rural" — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Wakenda RFD # 1 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Henry Middle Clarence Last Brockert
4. DATE OF DEATH: Month Jan. Day 1 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 29, 1877
9. AGE (In years last birthday) 81 — 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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (City and state or country) Oakville Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME George E.Brochert
13b. MOTHER'S MAIDEN NAME Sarah Frizzell
14. NAME OF HUSBAND OR WIFE Sarah Rhoades Brochert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs.John Thomas Address Wakenda, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Embolism — minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Myocarditis 4. — years
DUE TO (c) Valvular Leakage
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-8-58, to 1-1-59 and last saw her/him alive on 1-1-59.
Death occurred at 6:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [illegible] (Degree or title) — 22b. ADDRESS Carrollton Mo — 22c. DATE SIGNED 1-1-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 23b. DATE 1/4/1959 — 23c. NAME OF CEMETERY OR CREMATORY Dover Cemetery — 23d. LOCATION (City, town, or county) Dover (State) Mo.

24. FUNERAL DIRECTOR ADDRESS Standley-Gibson, Carrollton, Mo. — 25. DATE RECD. BY LOCAL REG. Jan 6-1959 — 26. REGISTRAR'S SIGNATURE Pearl Koch

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

C. Wetzel, D.

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 James F. Gibson, Student Embalmer No. 572 working under my personal supervision.

Student James F. Gibson
Signature of Student Embalmer

Signed Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.