

**DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
 FILED VS JUL 11 1960

**=60-023740**  
 STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Fairfield</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		c. CITY OR TOWN <u>Lancaster</u>	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pershing Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>236 E. 6th Avenue</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Rodrig</u> Middle <u>Bernard</u> Last <u>Halderman</u>			4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>60</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-01</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Mfg.</u>	11. BIRTHPLACE (City and state or country) <u>Lancaster, Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>George Halderman</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie Bower</u>	14. NAME OF HUSBAND OR WIFE <u>Marian</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Nellie Halderman, Lancaster, Ohio</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Concussion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Auto Accident</u>		
DUE TO (c) <u>Multiple bruises and broken bones</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Collision of 59 Rambler and milk truck</u>
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20c. TIME OF INJURY <u>2:10 p.m.</u>	Hour Month, Day, Year <u>7-3-60</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>3 miles W. of Brookfield</u>	20f. CITY, TOWN, OR LOCATION <u>Brookfield</u>	COUNTY <u>Linn</u>	STATE <u>Mo.</u>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 2:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. R. Wright</u>	(Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Medville Mo.</u>	22c. DATE SIGNED <u>7-4-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 4, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Rose Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lancaster, Ohio</u>
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24. FUNERAL DIRECTOR <u>Wright Funeral Home, Brookfield, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-4-60</u>	26. REGISTRAR'S SIGNATURE <u>Katherine Johnson</u>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

JUL 12 1960

JUL 25 1960

**STATEMENT BY LICENSED EMBALMER**

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harold B. Wright*

Licensed Embalmer No. 3718

P. O. Address Brookfield,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.