

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## -60-027326

FILED VS AUG 3 1960 157

Primary Registration District No. 3028

Registrar's No. 159

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jasper</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u> Length of stay in lb <u>63 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune-Brooks Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Carthage</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1001 W. Chestnut</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frank</u> Middle <u>Oscar</u> Last <u>Bloom</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>29</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2-27-97</u>	<b>9. AGE (last birthday)</b> <u>63</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> <b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>laborer</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Jasper County, Mo.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		<b>13a. FATHER'S NAME</b> <u>Peter Bloom</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Caroline Setterberg</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Ben Bloom</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>494-18-6420</u>			
<b>17. INFORMANT</b> <u>Ben Bloom</u>		<b>Address</b> <u>419 Oak Carthage, Mo.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound skull fracture</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>multiple facial fractures</u> 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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Hit in head by falling rock</u>			
<b>20c. TIME OF INJURY</b> Hour <u>9:30</u> a.m. <u>  </u> Month, Day, Year <u>7-29-60</u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Independent Gravel Co. Carthage</u>			
<b>20f. CITY, TOWN, OR LOCATION</b> <u>Jasper</u>		<b>COUNTY</b> <u>Mo.</u>		<b>STATE</b> <u>Mo.</u>			
<b>21. I attended the deceased from</b> <u>7-29-60</u> to <u>7-29-60</u> and last saw him alive on <u>7-29-60</u> Death occurred at <u>9:45 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Richard P. Coker, M.D.</u>			<b>22b. ADDRESS</b> <u>116 W. Third, Carthage, Mo.</u>		<b>22c. DATE SIGNED</b> <u>7/29/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>		<b>23b. DATE</b> <u>8-1-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Park Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Carthage, Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Knell Mortuary, Carthage, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-30-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>E M Clinton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 5 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 Frank W. Knull

Licensed Embalmer No. 4440

P. O. Address Carthage

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