

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038037

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 282 Primary Registration District No. _____ Registrar's No. 129

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Polk</u>				a. STATE <u>Mo</u>		b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Southwest Marion</u>			Length of stay in 1b <u>4 Weeks</u>	c. CITY OR TOWN <u>Aldrich, Mo</u>		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>Pleasant View Nursing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>None</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year	
First <u>James</u>		Middle <u>Arvellee</u>		Last <u>Bruce</u>		<u>November 1, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 19, 1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Dade County</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James M. Bruce</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Simms</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Bruce Deceased</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.		17. INFORMANT <u>Ruel Bruce Bolivar, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <u>4 8 hours</u>	
IMMEDIATE CAUSE (a) <u>Left lower lobe pneumonia</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)						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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>10/5/61</u> to <u>11/1/61</u> and last saw him alive on <u>11/1/61</u> Death occurred at <u>6:45 P. M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>[Signature], M.D.</u>				22b. ADDRESS <u>108 N. Mason</u> <u>Bolivar, Mo</u>		22c. DATE SIGNED <u>2 Nov 61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge</u>		23d. LOCATION (City, town, or county) <u>S. W. Aldrich,</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Saul D. Butler</u> Bolivar, Mo			25. DATE RECD. BY LOCAL REG. <u>Nov. 4, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Ralph Gordon per Jewell Gordon</u>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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 Paul D Butler

Licensed Embalmer No. 4471

P. O. Address Bolivar, Pa

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.