

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS APR 18 1960

60-015046

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. \_\_\_\_\_ Registrar's No. 111

1. PLACE OF DEATH a. COUNTY <u>Henry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield Township</u>		Length of stay in 1b <u>2 years</u>	c. CITY OR TOWN <u>Clinton,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt. 2, Clinton, Mo.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. # 2, Clinton, Mo.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Fitzhugh</u> Last <u>Bronaugh</u>			4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</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>3-4-1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u> Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Calhoun, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>J. H. Bronaugh</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Redford</u>		14. NAME OF HUSBAND OR WIFE <u>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. <u>None*Unknown</u>	17. INFORMANT <u>RFD. # 2,</u> Address <u>Clinton, Mo.</u>		
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>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>					10-12 yrs
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 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>1952</u> , to <u>Apr. 12, 1960</u> and last saw <u>him</u> alive on <u>Apr. 12, 1960</u> Death occurred at <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>James O. Smith M.D.</u> (Doctor or title)			22b. ADDRESS <u>106 S. Third St, Clinton, Mo.</u>		22c. DATE SIGNED <u>4/15/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 15, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clinton, Mo. Rural</u> (State)	
24. FUNERAL DIRECTOR <u>H. J. Bousard, Clinton, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>April, 15, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Willard Bigum</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *W. H. Hansen*

Licensed Embalmer No. 377

P. O. Address Gilbert,

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.