

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHDR. GOOD
State File No. 9393

BIRTH NAME MAR 23 1953		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 266			
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY GREENE					
b. CITY (If outside corporate limits, write RURAL and give township) SPRINGFIELD				c. CITY (If outside corporate limits, write RURAL and give township) SPRINGFIELD					
d. FULL NAME OF HOSPITAL OR INSTITUTION 1245 S. FERGUSON				d. STREET ADDRESS (If rural, give location) 1245 S. FERGUSON					
3. NAME OF DECEASED (Type or Print)		a. (First) LOUIS		b. (Middle) RAPHAEL		c. (Last) BROCKMAN			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH MARCH 15 1879			
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY WATCHMAN		11. BIRTHPLACE (State or foreign country) BEUTEN, GERMANY			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME RAPHAEL BROCKMAN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE SARAH BROCKMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME MRS. SARAH BROCKMAN ADDRESS SPFLD. MO.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of hip ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary Site of Cancer DUE TO (c) not determined II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3-4 mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 12-16 , 19 53 , to 3-13 , 19 53 , that I last saw the deceased alive on 1-7 , 19 53 and that death occurred at 5 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE James T. Good M.D. (Degree or title)				23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 3-16-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3/16/53		24c. NAME OF CEMETERY OR CREMATORY TEMPLE ISRAEL		24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.			
DATE REC'D BY LOCAL REG. 3-18-53		REGISTRAR'S SIGNATURE Edith Williamson		25. FUNERAL DIRECTOR'S SIGNATURE H.H. LOHMEYER ADDRESS SPRINGFIELD, MO.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Walter C. Hamilton

Licensed Embalmer No. 3808

P. O. Address SPRINGFIELD, MO.

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 this body is not embalmed, fact should be so stated above.