

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NO.

45867

1. PLACE OF DEATH a. COUNTY McLennan		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission). a. STATE Texas b. COUNTY McLennan	
b. CITY (If outside corporate limits, write RURAL and give precinct no.) OR TOWN Waco		c. CITY (If outside corporate limits, write RURAL and give precinct no.) OR TOWN Waco	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If rural, give location) 2111 Colcord Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Louis		b. (Middle) Frank	
		c. (Last) Drucke	
4. DATE OF DEATH Sept. 22, 1955			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 3, 1888
9. AGE 66		YEARS 9	MONTHS 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cotton classer		10b. KIND OF BUSINESS OR INDUSTRY Cotton Firm	
11. BIRTHPLACE (State or foreign country) Texas		12. FATHER'S NAME L. J. Drucke	
13. MOTHER'S MAIDEN NAME Martha Peters		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give no. or dates of service) Yes	
15. SOCIAL SECURITY NO.		16. INFORMANT'S SIGNATURE <i>Mrs. L. L. Drucke</i>	
17. 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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
18a. DATE OF OPERATION		18b. MAJOR FINDINGS OF OPERATION	
19. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		TEXAS DEPARTMENT OF HEALTH REC'D OCT 11 1955 BUREAU OF VITAL STATISTICS	
20a. ACCIDENT SUICIDE HOMICIDE (Specify)	20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20c. (CITY, TOWN, OR PRECINCT NO.)	(COUNTY) (STATE)
20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. HOW DID INJURY OCCUR?	
21. I hereby certify that I attended the deceased from September 18, 55 to 9-22- , 19 55 , that I last saw the deceased alive on 9-22- 19 55 , and that death occurred at 1:50P m., from the causes and on the date stated above.			
22a. SIGNATURE <i>Ralph Compton MD</i>		22b. ADDRESS 2320 Columbus Avenue Waco, Texas	
22c. DATE SIGNED 9-22-55			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 24, 1955	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross			
23d. LOCATION (City, town, or county) (State) Waco Texas		24. FUNERAL DIRECTOR'S SIGNATURE <i>F. M. Compton & son</i>	
25a. REGISTRAR'S FILE NO. 657		25b. DATE REC'D BY LOCAL REGISTRAR SEP 26 1955	
25c. REGISTRAR'S SIGNATURE <i>Margaret Scott</i>			

NOTE THE INFORMATION CALLED FOR ON THE REVERSE SIDE