MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Shelby

Township Clay or Village ~~Blanket~~ or City (NO. St.; Ward)

Registration District No. 827

Primary Registration District No. 6089

File No. 30715

Registered No. 40

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Bridgeman Brunell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Jan (Month) 12 (Day), 1836 (Year)

AGE: 86 yrs. 7 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ~

BIRTHPLACE (City or town, State or foreign country): England

PARENTS

NAME OF FATHER: Ben Brunell

BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't Know

MAIDEN NAME OF MOTHER: Don't Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ben Brunell

(ADDRESS) Clarence Mo

Filed Aug 11, 1917. W. M. Baylis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 2 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 15, 1917, to Aug 2, 1917, that I last saw him alive on Aug 2, 1917, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis General.

97

(Duration) 20 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A. M. Wood M. D.

8-7, 1917 (Address) Lentner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 20 yrs. ___ mos. ___ ds. In the State 50 yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Maplewood Cem.

DATE OF BURIAL: Aug 3, 1917

UNDERTAKER: E E Hopper

ADDRESS: Clarence Mo

PLACE OF DEATH

County

Township
or
Village
or
City (NO. St.; Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

File No.

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

DATE OF BIRTH
(Month) (Day) 1 (Year)

AGE
yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
(Month) (Day) 191 (Year)

I HEREBY CERTIFY, that I attended deceased from , 191, to , 191, that I last saw h alive on , 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)
(Duration) yrs. mos. ds.

(Signed) M. D.

191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MARGIN RESERVED FOR BINDING