LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1 PLACE OF DEATH

County: Jeffer

Township: Central
or
Village:
or
City: Hillsboro (NO. ..... St.; ..... Ward)

Registration District No. 422 File No. 21439 B

Primary Registration District No. 5577 Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME: Ben Brooks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 SINGLE ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (Write the word)

6 DATE OF BIRTH: ~~July~~ (Month) not known (Day), 1922 (Year)

7 AGE: 66 yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Jeff Co Mo

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Jeff Co Mo

12 MAIDEN NAME OF MOTHER: England

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Jeff Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Herman Sumer
(Address): Hillsboro Mo

15 Filed 6, 1922, G W Gauche, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 6 (Month) (Day), 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from about 1 year, 191..., to ....., 191..., that I last saw him alive on June 30, 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

23 A 0 (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G M Mockter M. D.
July 6, 1922 (Address) Hillsboro

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL: Festus Mo

DATE OF BURIAL: July 8, 1922

20 UNDERTAKER: T. S. Byrd

ADDRESS: Festus

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day), 1..... (Year)

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day), 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS