LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

17168

1. PLACE OF DEATH
County: Caldwell — Registration District No.: 99 — File No.:
Township: Rockford — Primary Registration District No.: 5147 — Registered No.: 10
City: (No. ..., ... St. ..... Ward)

2. FULL NAME: Fannie Emeline Brooks.
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sep 23 - 1853
7. AGE: Years 70 — Months 8 — Days 20 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): Union County
(STATE OR COUNTRY): Kentucky

PARENTS
10. NAME OF FATHER: Thomas Gaudus
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Rock Castle Co Ky
12. MAIDEN NAME OF MOTHER: Nancy Morgan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Union Co Ky

14. INFORMANT: Thomas Brooks
(Address): Mirabile Mo.
15. FILED June 24, 1924 O. C. Mount D.S. for R. L. Mount REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 13 1924
17. I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to June 13, 1924 that I last saw her alive on June 13, 1924, and that death occurred, on the date stated above, at June 13 7 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82 H
(duration) ..... yrs. ..... mos. 20 ds.
CONTRIBUTORY (SECONDARY) 74a
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H A Cox, M. D
, 19 (Address) Mirabile Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mirabile Mo Cem — DATE OF BURIAL: June 14 1924
20. UNDERTAKER: Alspaugh + Cowley — ADDRESS: Polo Mo

Deceased

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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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long is U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED..... , 19 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....d.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

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

20. UNDERTAKER | ADDRESS

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