

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

Do not use this space.

AUG 16 1927

21141

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2001
 City Springfield (No. 796 Lincoln)
 St. _____ Ward _____

2. FULL NAME John H. Brooks
 (a) Residence. No. 796 Lincoln 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.

File No. _____
 Registered No. 420
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16-1847
 7. AGE YEARS MONTHS DAYS 'If LESS than 1 day, _____ hrs. or _____ min.
79 11 20
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (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) Mo. Cav.
 10. NAME OF FATHER R. H. Brooks
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo. Cav.
 12. MAIDEN NAME OF MOTHER Ann Desousa
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo. Cav.

14. INFORMANT Lillian Brooks
 (Address) Springfield, Mo.
 15. FILED 7/6 1927 Clifford M. A. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1927
 17. I HEREBY CERTIFY, That I attended deceased from July 4, 1927 to July 6, 1927
 that I last saw him alive on July 4, 1927, and that death occurred, on the date stated above, at 5:50 a. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Stomach
H.P.B.
43D. 44A
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) myocarditis
 (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED Springfield mo
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Chemical
 (Signed) J. H. Ferguson, M. D.
 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.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Old Olive Cemetery DATE OF BURIAL July 8 1927
 20. UNDERTAKER W. H. Lengner ADDRESS 424 Commercial Springfield, Mo.

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.

