NOV 22 1928

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

Do not use this space.

35758

1. PLACE OF DEATH
County Shannon — Registration District No. 873
Township Winona — Primary Registration District No. 607
City ..... (No. ....., ... St. ..... Ward)
File No. .....
Registered No. .....

2. FULL NAME Samuel Alexander Greer Brawley

(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Sarah Benda Brawley

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 21 - 1877

7. AGE — Years: 51 — Months: 2 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Philadelphia
(STATE OR COUNTRY): Tenn

PARENTS

10. NAME OF FATHER: Neil Brawley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): North Carolina
12. MAIDEN NAME OF MOTHER: Luvica Swanson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): North Carolina

14. INFORMANT: Wright Brawley
(Address): Winona Mo

15. FILED Oct 25, 1928 Mabel Rogers
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 24 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1928 to Oct 24, 1928 that I last saw h. alive on Oct 21, 1928, and that death occurred, on the date stated above, at 9:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Inflamation of Bowels or Ileo colitus
(duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) S. E. Lehenbauer M. D
Oct 24, 1928 (Address) Winona 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Falling Spring Cemetery — DATE OF BURIAL: Oct 25 1928
20. UNDERTAKER: None — 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.

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