

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

Do not use this space.

7375

1. PLACE OF DEATH

County New Madrid
Township Como
City Danna (No.)

Registration District No. 605-
Primary Registration District No. 4359

File No.
Registered No.
St. Ward)

2. FULL NAME

Harry Braunam

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Faith Braunam

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 20, 1896

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	32	6	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work hammer
(b) General nature of industry, business, or establishment in which employed (or employer) farm work
(c) Name of employer Fred Thompson

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

10. NAME OF FATHER Tom Braunam

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

12. MAIDEN NAME OF MOTHER Ella Hamilton

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

14. INFORMANT Faith Braunam
(Address) Berna, Mo. R# 2

15. FILED 2/17, 1929 Mrs. S. Blochman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 19, 1929

17. I HEREBY CERTIFY, That I attended deceased from January 19, 1929, to Feb 7th, 1929 that I last saw him alive on Feb 5th, 1929, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY) Double Lobar Pneumonia
(duration) yrs. mos. 19 da.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH.
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms
(Signed) J. E. Mitchell, M. D.
, 19 (Address) Malden 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 Rosewood Emtery Malden Mo. DATE OF BURIAL 2/8 1929

20. UNDERTAKER ✓
ADDRESS ✓

PARENTS

To be sent to } Dr S. E. Mitchell.
Malden
Ma

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

2-29
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County New Madrid Registration District No. 605- File No.
 Township Primary Registration District No. 435-9 Registered No.
 City Osanna (No.) St. Ward)

2. FULL NAME Dave Brannon

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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)

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 2/15/29 Mrs C.S. Blackwell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 5 19 29

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

..... (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.

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

19

20. UNDERTAKER ADDRESS

certificste did not say X X

SUPPLEMENTARY

S-7375