

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

Do not use this space.

21150

1. PLACE OF DEATH

County.....*Gasconade*
Township.....*Clay*
City.....*Life* (No.....) St..... Ward.....

Registration District No.....*302*
Primary Registration District No.....*6231*

File No.....
Registered No.....

2. FULL NAME

Mary E. Branson
(a) Residence. No..... St..... Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred *Life* mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF *Charles H. Branson*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 4-1876*
7. AGE *52* YEARS MONTHS *9* DAYS *17* IF LESS than 1 day, hrs. 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) (STATE OR COUNTRY)

Gasconade Co. Mo.

10. NAME OF FATHER

Wash. Branson

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

Genoa

12. MAIDEN NAME OF MOTHER

Francis

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

Genoa

14.

INFORMANT *David J. Branson*
(Address) *St. Louis Mo.*

15.

FILED *6/20/29* REGISTRAR *C. A. Brung*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-18-1929*
17. I HEREBY CERTIFY That I attended deceased from *6-16-1929* to *6-18-1929* that I last saw *her* alive on *6-18-1929* and that death occurred, on the date stated above, at *9:00 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82A Hemorrhage of brain
174
CONTRIBUTORY (SECONDARY) *High blood pressure*
(duration) yrs. mos. da.

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) *Edw. Muller*, M. D.
6-20, 1929 (Address) *Commercial 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

DATE OF BURIAL

Oak Forest Cemetery *6-21-1929*

20. UNDERTAKER

ADDRESS

Charles A. Haight *Blount Mo.*

25

Chas. H. Johnson

Memorandum

Handwritten notes

Chas. H. Johnson

Handwritten notes