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

Do not use this space.

34383

1. PLACE OF DEATH

County Macon — Registration District No. 535 — File No.

Township Narrows — Primary Registration District No. 5720 — Registered No.

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

2. FULL NAME Minnie Brammer

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March, 5 1864

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	7	12	

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) Macon Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Jonathan Brammer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Sallie Peterson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Macon Mo

14. INFORMANT Mrs Minnie Brammer
(Address) Macon Mo R 10

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

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/15 1929

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 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suicide by Well Jumping in Well
166 (duration) ..... yrs. 2 mos. ..... ds.
84
CONTRIBUTORY (SECONDARY) Circulus Insanity
(duration) ..... yrs. 2 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 169
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) A M Russell M. D.
10/15, 1929 (Address) Macon 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
Mt Allen	10/20 1929

20. UNDERTAKER	ADDRESS
Albert Spencer	Macon Mo

N. B.—Every item of information [illegible] fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so [illegible] may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Macon — Registration District No. 535 — File No. 1

Township Narrows — Primary Registration District No. 5720 — Registered No. 112

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

2. FULL NAME Munroe Brammer

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 5 - 1864

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	7	10	

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) Macon Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Jonathan Brammer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Sadie Peterson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Macon Mo

14. INFORMANT Mrs Mame Brammer
(Address) Macon Mo R.F.D.

15. FILED Jan 10, 1930 J. J. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15 1929

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 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suicide by jumping in well
..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Circular Insanity
..... (duration) ..... yrs. 2 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) A. M. Reeves, M. D.
10/15, 1929 (Address) Macon 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
Mt Olive	10/20 1929

20. UNDERTAKER	ADDRESS
Albert Skinner	Macon Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT PREPARE OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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cated by check marks, lacking from the death certificate:

Name: Munroe Brammer

Who died at: Macon Co. on Oct. 15, 1929,

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years ____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Suicide by Jumping in well

Contributory: Circular Insanity
Drowned in 20 feet of water

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____ _____

Name of physician: A M Rynn

Address of physician: Macon Ins

The information [illegible] statistical purposes. Present return of

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