

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.

JUN 2 6 1930

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

Do not use this space.

20136

53

1. PLACE OF DEATH

County New Madrid

Registration District No. 604

Township 1

Primary Registration District No. 5802

City St. Robert (No. 1)

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

Robert Brennan

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Don't know

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Don't know

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 33 - 11 - 2

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

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 Will Banks & Pearce (Address) New Madrid, Mo

15. FILED 4/8 1930 W. O. Brennan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-16 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-16 1930, to 6-16 1930 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 7 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

183
Asphyxiation
accidental fall in Stroom
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 180 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY no

WHAT TEST CONFIRMED DIAGNOSIS Physiul signs
(Signed) W. H. Dwyer M. D.
19 _____ (Address) New Madrid 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 Evergreen Cem. DATE OF BURIAL 6-18 1930

20. UNDERTAKER Richards and Co ADDRESS New Madrid

