

SEP 24 1930

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

Do not use this space.

26221

1. PLACE OF DEATH

County Call

Registration District No. 913

File No. _____

Township _____

Primary Registration District No. 2014

Registered No. 190

City Jefferson (No. _____)

St. _____ Ward _____

2. FULL NAME

Sheridan Alton Brauser

(a) Residence. No. 1001 Jackson St., _____ Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 3 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

Rosa Monahan

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

Oct 3

7. AGE

YEARS 65

MONTHS 10

DAY 15

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Labour

(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)

Knoxville Tenn

10. NAME OF FATHER

Alton Brauser

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

12. MAIDEN NAME OF MOTHER

SK

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

SK

14. INFORMANT

(Address)

Mrs J J Madley 1001 Jackson St

15. FILED

FILED _____ 19 _____

9/18/30 J Bradford

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18 1930

17.

I HEREBY CERTIFY, That I attended deceased from Aug 12 to Aug 18 1930 that I last saw him alive on Aug 18 1930 and that death occurred, on the date stated above, at 30 min.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Baillary dysentery

(duration) _____ yrs. _____ mos. 12 ds.

CONTRIBUTORY (SECONDARY)

16 10

(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 Stool

(Signed) H. J. Taylor M. D.

8/19 1930 (Address) Jefferson City 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

Hart Hill Aug 19 1930

20. UNDERTAKER

ADDRESS

Brauser-Taylor

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.

1911

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**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 Boone
 Township Jeff City
 City Jeff City (No.)

Registration District No. 213
 Primary Registration District No. 3014

File No.
 Registered No. 190 St. Ward)

2. FULL NAME

Sheridan Almon Branson

(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) Oct 31 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 - 10 - 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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 9/8/20 W. Beard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18 1920

17. I HEREBY CERTIFY, That I attended deceased from
 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:

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

20. UNDERTAKER ADDRESS

N. B. ... PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. THEY ARE COMPLETE AS PRESCRIBED BY LAW. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES.

SUPPLEMENTARY

5-26221