

N. B.—E-1
CAUSE OF DEATH in plain form, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC 22 1930

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

Do not use this space.

36626X

1. PLACE OF DEATH

County Knox
Township Center
City Edina Mo (No.)

Registration District No. 443
Primary Registration District No. 4259

File No.
Registered No. 73 St. Ward

2. FULL NAME Budget Brennan

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

Patrick Brennan

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

7. AGE

YEARS
84

MONTHS

6

DAYS

7

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)

Ireland

10. NAME OF FATHER

Brennan

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

Ireland

12. MAIDEN NAME OF MOTHER

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

Ireland

14.

INFORMANT (Address)

Mrs. Mary Moran
Edina Mo

15.

FILED

12-10 19 30

Geo. Brown
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 10, 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1929, to Nov. 10, 1930, that I last saw him alive on Nov. 2, 1930, and that death occurred, on the date stated above, at 8:00 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia

CONTRIBUTORY (SECONDARY) Chronic Myocarditis - Atherosclerosis

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? Clin. History + Phys. Exam.

(Signed) W. H. Langstaffer, M.D.

Nov 11, 1930 (Address) Edina 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

St. Joseph Cemetery

Nov 11 1930

20. UNDERTAKER

ADDRESS

Kriegshauser Bros Edina Mo

Excluded. Exact location of Ocean. In the ocean.

**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 Knox
Township Edina
City Edina (No. St. Ward)

Registration District No. 441
Primary Registration District No. 4239

File No.
Registered No. 73

2. FULL NAME

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

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.
84 6 7

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 12/10/30 Geo. S. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 19 30

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

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.—Every item of information should be carefully supplied. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. If in doubt, state "Under medical treatment." Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A. FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-36626