

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

Do not use this space.

1. PLACE OF DEATH

County Cass Registration District No. 161 File No. 31703
Township Dayton Primary Registration District No. 5226 Registered No. 9
City Dayton (No. _____) St. _____ Ward _____

2. FULL NAME Albert Brooks

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

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

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

7. AGE YEARS 75 MONTHS 2 DAYS 13 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 43

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cass Co., Mo.

13. NAME Thomas Brooks

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 2

15. MAIDEN NAME Pearl Williams

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Lilie Brooks Garden City.

18. BURIAL, CREMATION, OR REMOVAL PLACE Dayton Com t y DATE Oct. 31 1932

19. UNDERTAKER J.M. Kuffman Garden City, Mo.

20. FILED Oct 31 1932 Mrs. Malcol Wagner Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 29 1932

22. I HEREBY CERTIFY, That I attended deceased from May 10 1932 to Oct 29 1932
I last saw him alive on Oct 26 1932 Death is said to have occurred on the date stated above, at 11 a m.

The principal cause of death and related causes of importance were as follows:

Gall Stones Date of onset 12/6 1926
Pyrexia 12/6

Other contributory causes of importance:

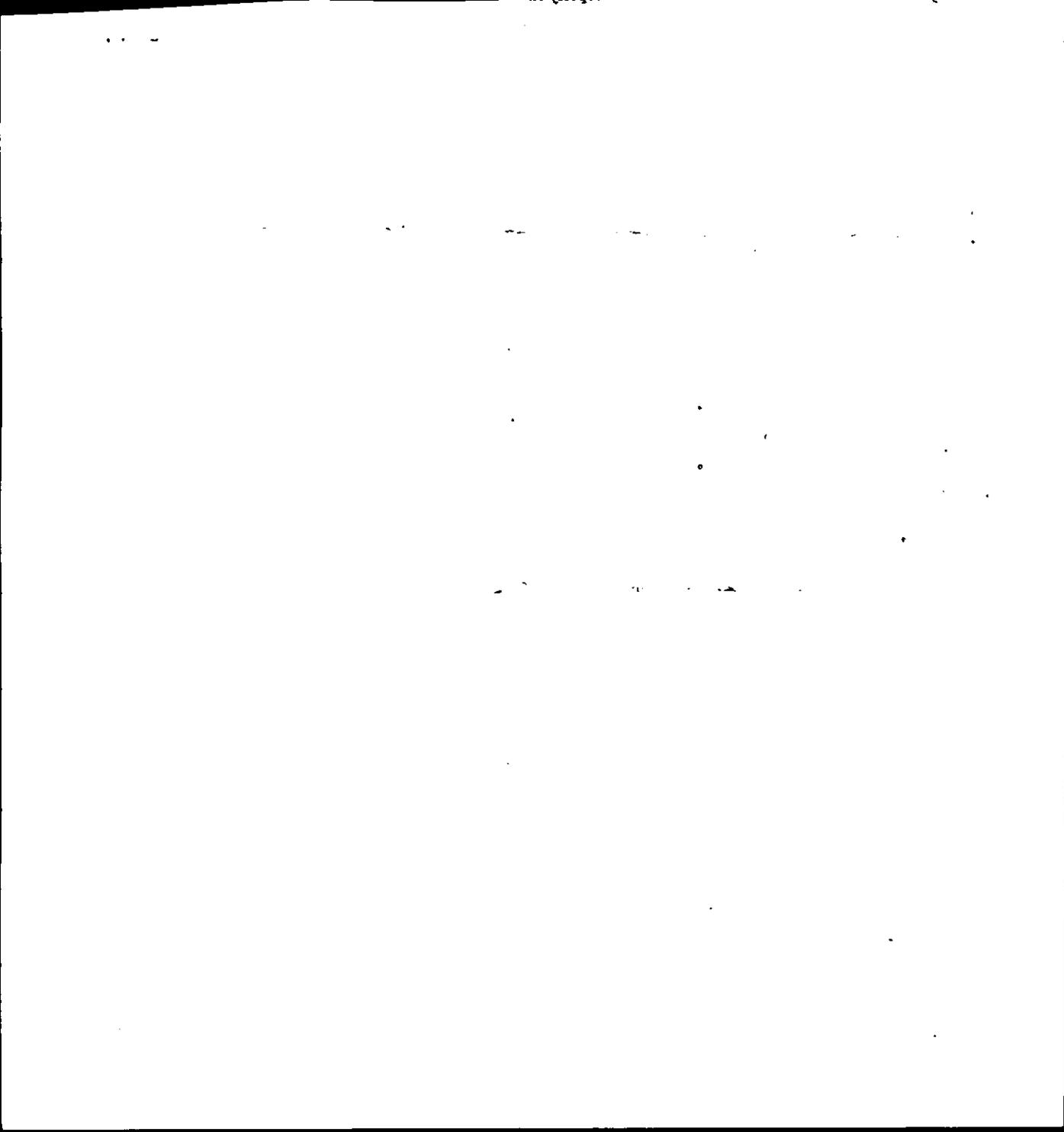
Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) J.M. Kuffman, M. D.
(Address) Brook Mo

NOV 22 1932



**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 Cass Registration District No. 161
Township Dayton Primary Registration District No. 5226
City (No. _____) St. _____ Ward _____

2. FULL NAME

Albert Brooks

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

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) Aug. 17, 1857
7. AGE YEARS MONTHS DAYS If LESS than 11 day, hrs. or min.
75- 2 12

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED Oct 31, 1932 Mrs. Mabel Wagner Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 29, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of case

Other contributory causes of importance: _____

Name of operation _____ Date of _____

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

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

S-31703