

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

Do not use this space.

FEB 27 1934
FEB 27 1934

2238

PLACE OF DEATH

County Salt Springs
Township Salt Springs
City No.

Registration District No. 733
Primary Registration District No. 5967

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Annice Frances Brockman

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
6 6 10

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) Randolph Co. Mo

MOTHER 13. NAME Grover Brockman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co.

15. MAIDEN NAME Annice Bell Spicer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co.

17. INFORMANT Grover Brockman
(ADDRESS) Highway 2 #

18. BURIAL, CREMATION, OR REMOVAL PLACE Oakland DATE 1-4 1934

19. UNDERTAKER Swan Undertakers
(ADDRESS) W. 4th St. No.

20. FILED Jan 5 1934 D. P. Hamrad Registrar.

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-2-1934 .19

22. I HEREBY CERTIFY, That I attended deceased from January 1, 1932, to Jan 2, 1934.
I last saw her alive on Jan 2, 1934. Death is said to have occurred on the date stated above, at 6:30 P.M.

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

Brain Tumor
at base of brain
Paralysis both legs
extreme emaciation
atrophy of muscles
Other contributory causes of importance: _____
Convulsions (seizures)
54D
83D
1518
Name of operation _____ Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No.

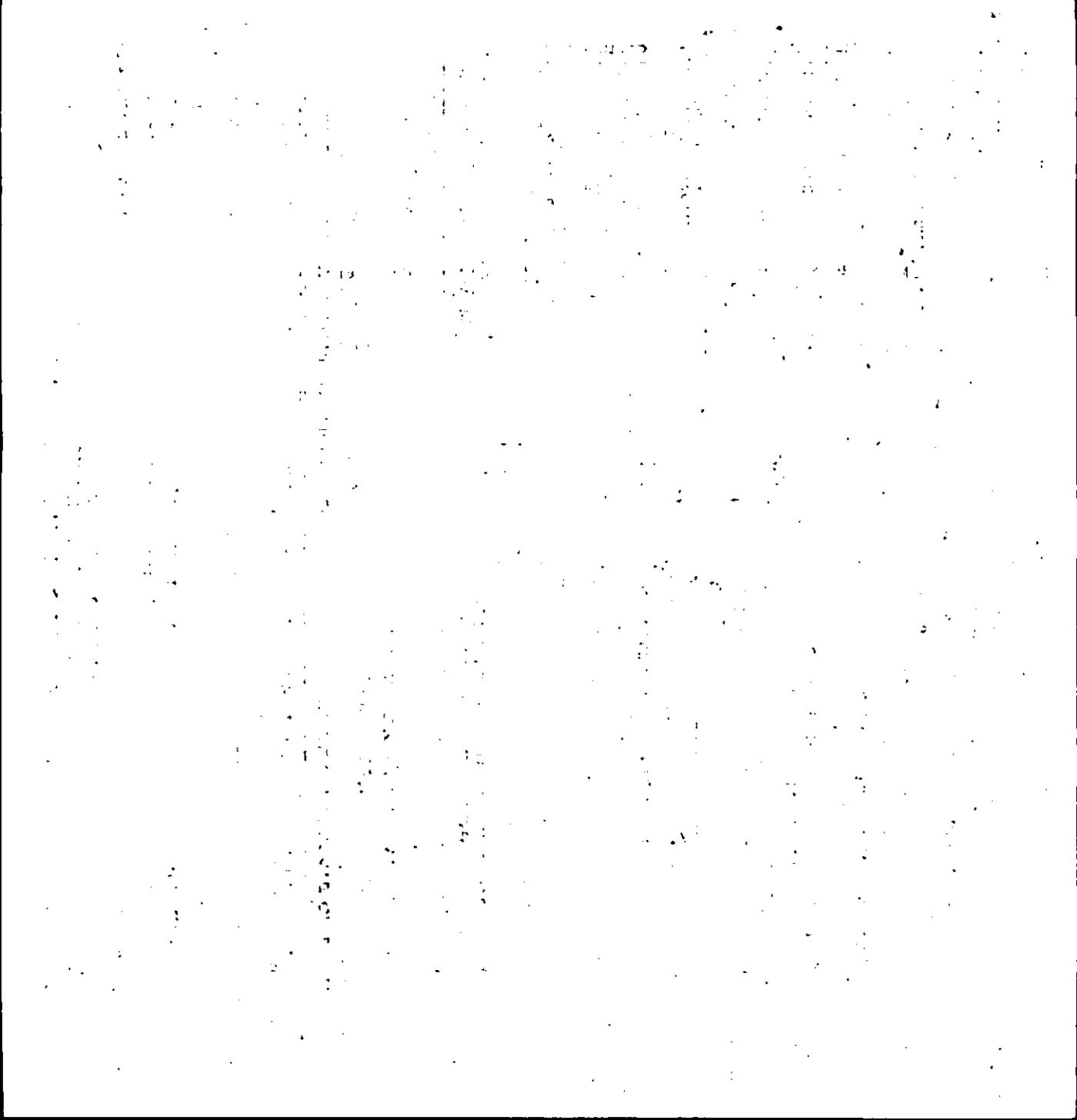
Date of onset 1-1-32

8-1-33

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) C. F. Burnhatter, M. D.
(Address) Highway No.



**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 Franklin
Township Walt & Grange
City St. Louis (No.)

Registration District No. 733
Primary Registration District No. 2967

File No. 2238
Registered No.

2. FULL NAME

Annie Frances Brockman

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

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.

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)

13. NAME

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

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 19 W. D. Barnhart Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2, 1934

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

I last saw h. alive on , 19 . Death is said to have occurred on the stated above, at m.

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

Benign Tumor of base of brain
No indications of malignancy
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) G. F. Burkholder, M. D.

(Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-2238