

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

Do not use this space.

5608

MAR 24 1934

1. PLACE OF DEATH

County Linn
 Township Morris
 City _____ (No. _____)

Registration District No. 492
 Primary Registration District No. 571

File No. 234
 Registered No. 2
 St. _____ Ward _____

2. FULL NAME

Frank Brunert

(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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) M 13 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 4 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Linn Co Mo
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER Steve Brunert
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Catherine Freize
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

14. INFORMANT J. Lee Brunert
 (Address) Ethel M. Mo.

15. FILED Feb 19 34 REGISTRAR C. H. ...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 26 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1934 to Feb 26 1934 that I last saw him alive on 23 Feb 1934, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Phosphorus Nephritis
131

56 E (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Phosphorus
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Physiocal
 (Signed) J. O. Shepley, M. D.

Address Moscow Mills 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 Marys Cemetery March 1934

20. UNDERTAKER ADDRESS

Wendie Keithly Redwine
Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S usual state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

N. B.—Every item of material should be stated EXACTLY. PHYSICIAN'S NAME OR DRUG NAME

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lincoln
Township Manover
City..... (No..... Ward)

Registration District No. 492
Primary Registration District No. 56522

File No. 5608
Registered No..... St..... Ward)

2. FULL NAME

Frank Brunwert

(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) m

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.
	<u>72</u>	<u>11</u>	<u>13</u>	

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 6/10 1934 [Signature] Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/26 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 date stated above, at..... m.

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

Date of onset

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

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

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