

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.

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

Do not use this space.

7
FEB 8 1935

1. PLACE OF DEATH

County Deming
Township Franklin
City Franklin (No. _____)

Registration District No. 655
Primary Registration District No. 587V

File No. 17623-2
Registered No. _____
St. _____ Ward _____

2. FULL NAME Edith 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 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>C</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>L</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>7-10-1915</u>		
7. AGE YEARS <u>18</u>	MONTHS <u>10</u>	DAYS <u>19</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farming</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>L</u>	
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation <u>L</u>	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Walls Miss.

MOTHER FATHER 13. NAME Jal Brooks

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

15. MAIDEN NAME Saphil Mc Coy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Walls Miss.

17. INFORMANT (ADDRESS) Jal Brooks
Franklin MO

18. BURIAL, CREMATION, OR REMOVAL PLACE Holly Gravel DATE 6-30-34

19. UNDERTAKER (ADDRESS) Herman York Co
Franklin MO

20. FILED 6/1 19 34 Max Hiley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-29 1934

22. I HEREBY CERTIFY, That I attended deceased from March 2, 1934, to May 5th, 1934. I last saw him alive on May 2, 1934. Death is said to have occurred on the date stated above, at 5 P. m.

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

Pulmonary Tuberculosis
23A
2 2
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? no
If so, specify: _____
(Signed) James P. Vickrey, M. D.
(Address) Franklin MO

