

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

Do not use this space.

**1. PLACE OF DEATH**

County Cape Girardeau Registration District No. 130  
Township Nelch Primary Registration District No. 5175  
City \_\_\_\_\_ State \_\_\_\_\_ Ward \_\_\_\_\_

File No. 23593  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Mrs. Eva Brees  
(a) Residence No. Randles, Mo. 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-27-1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
41 4 8

**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) unknown  
(STATE OR COUNTRY)

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Aloy Brees  
(Address) Randles, Mo.

15. FILED 7/16 1934 J. M. S. Degeh REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5-1934

17. I HEREBY CERTIFY That I intended deceased from July 3, 1934 to July 5, 1934 that I last saw her alive on July 5, 1934 and that death occurred, on the date stated above, at 6 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Syphilis  
(duration) 10 yrs. 0 mos. 0 ds.  
CONTRIBUTORY (SECONDARY) 34  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

(Signed) A. S. H. Burton M. D.  
7-5-1934 (Address) Delta, 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 Perkins, Mo DATE OF BURIAL 7-6 1934

20. UNDERTAKER Aloy Brees ADDRESS Randles Mo

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.

AUG 13 1934

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