

JUN 25 1937

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

Do not use this space.

20995

1. PLACE OF DEATH

County *Shelby*
Township *St. James*
City

Registration District No. *678*
Primary Registration District No. *5904*
(No. *St. James Hospital*)

File No.
Registered No.
St. Ward

2. FULL NAME *Dale Gene Branson*

(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 *Male*
4. COLOR OR RACE *white*
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) *5-17-1937*
7. AGE - YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— — 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *none*
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) *St. James Mo*

13. NAME *Wayne A Branson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Cuba Mo*

15. MAIDEN NAME *Olga Grubler*

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

17. INFORMANT (ADDRESS) *A. L. Branson Cuba Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Licklider cem* DATE *5-19* 19*37*

19. UNDERTAKER (ADDRESS) *W. E. Licklider St. James Mo*

20. FILED *5-19-1937* *W. J. Dour Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-19* 19*37*

22. I HEREBY CERTIFY, That I attended deceased from *5-17* 19*37*, to *5-19* 19*37*.
I last saw ~~her~~ *him* alive on *5-19* 19*37*. Death is said to have occurred on the date stated above, at *1:45 a. m.*
The principal cause of death and related causes of importance were as follows:

Granular - Salivary insufficiency
Date of onset: *5-17-37*
Other contributory causes of importance: *Granularly undetected* *159*

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) *J. R. Scott*, M. D.
(Address) *St. James Hospital*

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.

