

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

**1991**  
Do not use this space.

1. PLACE OF DEATH **REC'D FEB 21 1939** **Clark 3**

(a) County **Vernon** Registration District No. **189**  
 (b) Township **Vernon** Primary Registration District No. **52.63** Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **620 Ephraim Edward Brooks**

(a) Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (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 **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Georgia Logue Brooks**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 18, 1884**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**54 8 20**

OCCUPATION 8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **Laborer**  
 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) **Fort Collins, Colorado**

FATHER 13. NAME **D. M. Brooks**  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **East Berlin, Michigan**

MOTHER 15. MAIDEN NAME **Mary Allen**  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Tharion, Mo**

17. INFORMANT (ADDRESS) **Mrs. Edward Brooks, Alexandria, Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Prague Cemetery, DATE Feb 10 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **H. K. Kirchner, Wayland, Mo**

20. FILED **Feb 10 1939** **D. F. W. Rebo** Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 8 1939**

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. 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:  
**killed by train**  
**C. & G. R.R.**  
 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? **homicide** Date of injury **Feb 8, 1939**  
 Where did injury occur? **near Alexandria, Mo**  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
**near Alexandria, Mo C & G R.R.**  
 Manner of injury **killed on right of way**  
 Nature of injury **cut all to pieces**

24. Was disease or injury in any way related to occupation of deceased? **No**  
 If so, specify \_\_\_\_\_ (Signed) **H. A. S. Rebo**, M. D.  
 (Address) **Alexandria, 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.

175a

RECEIVED

District Health Officer No. 10

District File Number 10-39-60

Date Filed FEB 14 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate, was embalmed by me, \_\_\_\_\_

\_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF HEALTH  
STATE OF NEW YORK  
BUREAU OF HEALTH OFFICERS  
ALBANY, N. Y.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH OFFICERS  
ALBANY, N. Y.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1991  
Do not use this space.

1. PLACE OF DEATH

(a) County Clatsop Registration District No. 189  
(b) Township Jernon Primary Registration District No. 5263 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ephraim Edward Brooks  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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.  
34 8 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 8 1929

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

I last saw him alive on \_\_\_\_\_, 19\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Killed by train  
with 2 abdominal wounds  
Clark Co  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: 2078

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: Accident Date of injury Feb 8, 1929  
Where did injury occur? Near Aberdeen, Mo. Clark Co  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury run over by train No. 10 L.B. & N.R.R.

Nature of injury cut all 4 fingers walking on

24. Was disease or injury in any way related to occupation of deceased? Yes

If so, specify \_\_\_\_\_ way

(Signed) E. A. S. Revo, M. D.

(Address) Alexandria Mo

Every item of information should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. STRIPS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

Σ-1991