

1959 FEB 6 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

3196  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 603  
 (b) Township Woods Primary Registration District No. 4367  
 (c) City Morehouse (d) Street No. \_\_\_\_\_  
 (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

(a) Residence, No. 625 John Brockamp 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 Retired

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-12-18

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 11 6

OCCUPATION 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. Retired  
 10. Date deceased last worked at this occupation (month and year) Farmer 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Christian Co. Illinois

FATHER 13. NAME Joe Brockamp  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Illinois

MOTHER 15. MAIDEN NAME Frances Brockamp  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) H.E. Todd Morehouse

18. BURIAL, CREMATION, OR REMOVAL PLACE Morehouseville Ill. 12-18-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Abraham Anderson Sikeston Mo.

20. FILED 19 John Parrish Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-5-38 1938

22. I HEREBY CERTIFY, That I attended deceased from 12-5-38, 1938, to 12-18-38, 1938.

I last saw him alive on 12-17-38, 1938. 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:

Chronic interstitial nephritis.  
Emema.  
 Date of onset 1930

Other contributory causes of importance: 12/1

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? no

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) Howard M. Keady, M. D.  
 (Address) Sikeston Mo.

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**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.**