

REC'D MAR 13 1939

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

6597  
Do not use this space.

1. PLACE OF DEATH  
(a) County Greene Registration District No. 944  
(b) Township Washington Primary Registration District No. 5447B Registered No. 3  
(c) City Stratford (d) Street No. R# 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 DORSEY L. BROOKS  
(a) Residence, No. Stratford Mo. R# St.  (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 Almanzia E. Brooks  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 28, 1875

7. AGE YEARS 63 MONTHS 9 DAY 3 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as saw mill, bank, etc. on farm  
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) Mo.

FATHER 13. NAME John K. Brooks

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Car.

MOTHER 15. MAIDEN NAME Eliza J. Rudd

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

17. INFORMANT (ADDRESS) Mrs. G. E. Brooks Stratford, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wagon Cemetery Mar. 3, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Kingman Spruiggfield, Mo.

20. FILED Mar 3 1939 Clayton P. Anderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 11, 1938, to Feb 24, 1939  
I last saw him alive on Feb 24, 1939 Death is said to have occurred on the date stated above, at 7 P m.  
The principal cause of death and related causes of importance were as follows:

Myocardial degeneration 11/38  
Chronic Nephritis ?  
Other contributory causes of importance:

Name of operation Amput Date of 7/6  
What test confirmed diagnosis? Amput 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 Dr. H. Focht MD M. D.  
(Signed) Stratford Mo (Address) 297

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.

JAN 25 1945

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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 Roy A. Baum  
Licensed Embalmer, No. 1763  
P. O. Address Springfield, Ill.

**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.**