

REC'D APR 19 1939

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

10598
Do not use this space.

1. PLACE OF DEATH

(a) County COOPER Registration District No. 218
(b) Township 1 Primary Registration District No. 3015- Registered No. 40
(c) City BOONVILLE (d) Street No. ST. JOSEPH'S HOSPITAL 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 MRS GRACE RANDOLL BRODERSON

(a) Residence, No. 904 LOCUST ST. 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 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 W.C. BRODERSON		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 21 - 1897		
7. AGE	YEARS	MONTHS
	41	9
		DAYS
		21
		IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME	
	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) MARCH 1939	
	11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FLORENCE MISSOURI	
	13. NAME UNKNOWN	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
	15. MAIDEN NAME CAROLINE SANDERS	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FLORENCE MISSOURI	
17. INFORMANT REV. W.C. BRODERSON (ADDRESS) BOONVILLE, MO.		
18. BURIAL, CREMATION, OR REMOVAL Crown Hill Cemetery PLACE SEDALIA, MO. DATE March 16, 1939		
19. FUNERAL DIRECTOR (NAME) STEGNER & KOENIG (ADDRESS) BOONVILLE, MO.		
20. FILED 3-16-1939 DeHooper Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **MARCH 14**, 19**39**22. I HEREBY CERTIFY, That I attended deceased from **10-10**, 19**38**, to **3-14**, 19**39**I last saw her alive on **3-14**, 19**39**. Death is said to have occurred on the date stated above, at **7:40** p.m.
The principal cause of death and related causes of importance were as follows:**Leukemia, Myelogenous**Date of onset
1939

Other contributory causes of importance:

Influenza**3-7-39**Name of operation
What test confirmed diagnosis? **Laboratory tests** Date of
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
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 injury24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) **W. E. Stone**, M. D.197 (Address) **Boonville, Mo.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

I X-16605

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4/7/39

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 *James W. Segner*
Licensed Embalmer No. *37800*
P. O. Address *Boonville, Mo*

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.