

REC'D APR 15 1939

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

10667  
Do not use this space.

1. PLACE OF DEATH *Dent Co Mo*
- (a) County *Dent* Registration District No. *266*
- (b) Township *Salem mo* Primary Registration District No. *4164*
- (c) City *Salem mo* (d) Street No. \_\_\_\_\_ Registered No. *23*
- (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 *Thomas Jefferson Broyles*
- (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Susan Broyles</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan 12 - 1890</i>		
7. AGE <i>49</i>	YEARS <i>90</i>	MONTHS <i>4</i>
	DAYS <i>28</i>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>Farmer</i>	
	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) <i>Dent Co Mo</i>		
FATHER	13. NAME <i>Lewis Broyles</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>	
MOTHER	15. MAIDEN NAME <i>Don't Know</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>	
17. INFORMANT (ADDRESS) <i>Charley Broyles Salem Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Monument</i> DATE <i>3/7, 1939</i>		
19. FUNERAL DIRECTOR (ADDRESS) <i>N. D. Holton Salem Mo</i>		
20. FILED <i>March 6, 1939</i> <i>A. E. Smith</i> Local Registrar		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3/5 - 1939*

22. I HEREBY CERTIFY, That I attended deceased from *March 4, 1939, to March 5, 1939*  
I last saw him alive on *March 4, 1939*. Death is said to have occurred on the date stated above, at *9:30 p.m.*  
The principal cause of death and related causes of importance were as follows:  
*Apoplexy*

Date of onset *1939*

Other contributory causes of importance:  
*Hypertension 1939*

Name of operation *None* Date of \_\_\_\_\_

What test confirmed diagnosis *usual signs* Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? *No* 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) *O. G. Dillman*, M. D.  
(Address) *Salem Mo.*

(Licensed Embalmer's Statement on Reverse Side)

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.

FORM 7-20-37  
1 X 12004

STATEMENT BY LICENSED EMBALMER

I, N. D. Johnson, Licensed Embalmer No. 928  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by not. Embalmed at all

.....L. E. ....  
No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed N. D. Johnson  
Licensed Embalmer No. 928

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.)