

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.

REC'D MAY 12 1939

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

Do not use this space.

14197

1. PLACE OF DEATH

10  
20  
County Boone  
Township 1  
City Australia (No. 620)

Registration District No. 72  
Primary Registration District No. 4041

File No. 14197  
Registered No. 42  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME LAURA CATHERINE BROOKS

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

|   |   |   |
|---|---|---|
| 3. SEX<br><u>1</u>  | 4. COLOR OR RACE<br><u>w</u>  | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>The law</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF<br><u>John C. Brooks</u> |   |   |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)<br><u>June 11-1857</u>                        |   |   |
| 7. AGE  | YEARS<br><u>82</u>  | MONTHS<br><u>3</u>  |
|   | DAYS<br><u>7</u>  | If LESS than 1 day, _____ hrs. or _____ min.                                |
| OCCUPATION  | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.<br><u>Housewife</u>               |   |
|   | 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  |   |
|   | 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____ |   |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18, 1939

22. I HEREBY CERTIFY, That I attended deceased from May, 1938, to 4-18, 1939.

I last saw her alive on April 18, 1939. Death is said to have occurred on the date stated above, at 3:30 p. m.

The principal cause of death and related causes of importance were as follows:  
Paralysis (Cerebraloplexy) Date of onset 4/5/39

Other contributory causes of importance:  
Hypertensive Pneumonia 4/10/39

|   |   |
|---|---|
| FATHER  | 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Frederick Mo</u> |
|   | 13. NAME<br><u>Mitchell Deussen</u>                                     |
| MOTHER  | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Kentucky</u>     |
|   | 15. MAIDEN NAME<br><u>Werkmann</u>                                      |
| INFORMANT   | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Werkmann</u>     |
|   | 17. INFORMANT (ADDRESS)<br><u>Mrs Leo Staff Australia Mo</u>            |
| 18. BURIAL, CREMATION OR REMOVAL<br>PLACE <u>Frederick Mo</u> DATE <u>4-20</u> , 19 <u>39</u> |   |
| 19. UNDERTAKER (ADDRESS)<br><u>M. J. McDonald Australia Mo</u>                                |   |
| 20. FILED <u>H-19</u> , 19 <u>39</u> <u>F. H. Gardner, M.D.</u> Registrar.                    |   |

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? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1939  
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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Frank W. Gardner, M.D.  
31. (Address) Australia Mo

