

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.

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

21785
Do not use this space.

JUL 23 1939

1. PLACE OF DEATH

(a) County Carroll Registration District No. 138
 (b) Township Egypt Primary Registration District No. 4078 Registered No. 14
 (c) City Norborne (d) Street No. Cole'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. 4 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 638 Fay C. Brice Kansas City Mo 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE-OF Craton Brice

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 23 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 3 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Steel mill worker
 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) May 2, 1939
 11. Total time (years) spent in this occupation 20 yrs

12. BIRTHPLACE (CITY OR TOWN) Carroll Co.
 (STATE OR COUNTRY) near Norborne Mo.

13. NAME Amos B. Brice

14. BIRTHPLACE (CITY OR TOWN) Saline Co.
 (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Susan H. Wolfskill

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

17. INFORMANT (ADDRESS) Mrs. Miller Stevens
Norborne, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet DATE June 2 1939

19. FUNERAL DIRECTOR (ADDRESS) W. T. Stroud
Norborne, Mo.

20. FILED June 2 1939 B. C. Cole
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from May 28, 1939, to June 1, 1939
 I last saw him alive on June 1, 1939 Death is said to have occurred on the date stated above, at 5 a.m.
 The principal cause of death and related causes of importance were as follows:

Pericarditis Acute Date of onset 5-28-39
90

Other contributory causes of importance: Bronchial Asthma

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 _____, 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) Redskins, M. D.
 (Address) Norborne Mo

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7/11/39

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)