

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 JUL 8 1939 2

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

22570
 Do not use this space.

1. PLACE OF DEATH
 (a) County Juniata Registration District No. 496
 (b) Township Brookfield Primary Registration District No. 3025
 (c) City Brookfield Mo. (d) Street No. _____ 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 Anna Jane Mc Bride
 (a) Residence, No. St. Catherine 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Scott Mc Bride
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 17 - 1856
 7. AGE YEARS 83 MONTHS 2 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 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) St. Catherine Missouri
 FATHER 13. NAME Wm Mc Christie 1
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky 1
 MOTHER 15. MAIDEN NAME Lucinda Chamberlain
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 17. INFORMANT (ADDRESS) Eduyth Reid Brookfield Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Rose Hill Cemetery DATE June 18, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Brookfield Mo. W. H. Miller & Rollins Brookfield Mo.
 20. FILED July - 1 - 1939 Brookfield Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 16 - 1939
 22. I HEREBY CERTIFY That I attended deceased from June 14 - 1939 to June 16 - 1939.
 I first saw her alive on June 16 - 1939. Death is said to have occurred on the date stated above, at 5:45 p.m.
 The principal cause of death and related causes of importance were as follows:
Peritonitis of Stomach
 Date of onset 6 mo
 Other contributory causes of importance: HB
 Name of operation _____ Date of _____
 What test confirmed diagnosis? PA 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 _____
 (Signed) Wm H. Miller, M. D.
 (Address) Brookfield Mo.
445

RECEIVED

District Health Officer No. 117

District File Number 739-765

Date Filed JUL 6 1939

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 L. W. Collins

Licensed Embalmer No. 1144

P. O. Address Brookfield?

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.