

39 AUG 14 1939

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

25403  
Do not use this space.

1. PLACE OF DEATH

(a) County Clay Registration District No. 201  
 (b) Township Liberty Primary Registration District No. 5280 Registered No. \_\_\_\_\_  
 (c) City Liberty (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 3 yrs. 2 mos. 7 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles W. Brigham

(a) Residence, No. I.O.O.F. Home, Liberty, Mo. St.  (Usual place of abode, if no street address, write county or city)  
 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 14, 1855  
 7. AGE YEARS 83 MONTHS 7 DAYS 1  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. salesman  
 9. Industry or business in which work was done, as saw mill, bank, etc. nursery stock  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Dunkirk  
 (STATE OR COUNTRY) New York

13. NAME A. J. Brigham

14. BIRTHPLACE (CITY OR TOWN) New York  
 (STATE OR COUNTRY)

15. MAIDEN NAME Mariah Belcon

16. BIRTHPLACE (CITY OR TOWN) New York  
 (STATE OR COUNTRY)

17. INFORMANT Paul Rogers  
 (ADDRESS) I.O.O.F. Home, Liberty, Mo.

18. JOURNAL OF DEATH OR CORONER'S REPORT  
 PLACE Liberty, Mo. DATE 7/17 1939

19. FUNERAL DIRECTOR Hessel-Carder  
 (ADDRESS) Liberty, Mo.

20. FILED July 22 1939 W.H. Shaffer  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/15 1939

22. I HEREBY CERTIFY that I attended deceased from July 14 to July 15  
 I last saw him alive on July 14 1939 Death is said to have occurred on the date stated above, at 9 a m.  
 The principal cause of death and related causes of importance were as follows:

Fractured Hip!  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Diabetes Mellitus

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?  
 If so, specify Fractured Hip!  
 (Signed) J. M. Mathard M. D.  
at Liberty, Mo. (Address)

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**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 complete the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

25403  
Do not use this space.

1. PLACE OF DEATH

(a) County Clay Registration District No. 201  
(b) Township Liberty Primary Registration District No. 2280  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(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

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Charles H. Brigham  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
(write the word)

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

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

7. AGE YEARS 83 MONTHS 7 DAYS 1 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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)

FATHER

13. NAME \_\_\_\_\_  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME \_\_\_\_\_  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_, 19 \_\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/15 - 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19 \_\_\_\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Fractured Hip  
Diabetes Melitis  
Date of onset \_\_\_\_\_

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 Accident Date of injury 7/15/39

Where did injury occur? See Home Records (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place Home

Manner of injury from fall

Nature of injury Fractured Hip

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) J. H. Matthews, M. D.

(Address) Liberty Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-25403 1939