

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

K. 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

28545  
Do not use this space.

SEP 12 1939

1. PLACE OF DEATH

(a) County Boone Registration District No. 73

(b) Township Columbiu Primary Registration District No. 3006 Registered No. 162

(c) City Columbiu (d) Street No. Boone County 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME LEONARD F BROACH

(a) Residence, No. 129 Edgewood 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-9-1888

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

50 11 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Mgn. M.F.A.

9. Industry or business in which work was done, as saw mill, bank, etc. Oil Co.

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) Mississippi

FATHER 13. NAME Walter E Broach

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

MOTHER 15. MAIDEN NAME Mary Hughes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

17. INFORMANT (ADDRESS) Mrs. L. F. Broach  
Columbiu, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Elmo, Ill. DATE 8-9-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carrers  
Columbiu, Mo.

20. FILED 8/8/39 1939 Allie Selby  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-7-1939

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

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 1:30 P.m.

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

Acute appendicitis  
Peritonitis  
Dist. external obit. mat.

Date of onset 8/1/39

Other contributory causes of importance: 12/1  
Old abdominal adhesions from  
gunshot wounds in  
World War

Name of operation Appendectomy Date of 8/1/39

What test confirmed diagnosis? Op. Was there an autopsy? No

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? No  
(Specify city or town, county, and State)

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

Manner of injury No  
Nature of injury No

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) Dr. Robert M. D.  
(Address) Columbiu, Mo.

**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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Tom McHardy Jr

Licensed Embalmer No.

4467

P. O. Address

Columbia Tenn

**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.**