

REC'D SEP 8 1939

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

29588
Do not use this space.

1. PLACE OF DEATH *Linn* Registration District No. *496*
 (a) County *Linn* Primary Registration District No. *3025*
 (b) Township or City *Brookfield* Registered No. *82*
 (c) City *Brookfield* (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 *Kate E Hanna*
 (a) Residence, No. *107 Shelby* 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 *M* 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 *Perry Hanna*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 27 1876*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 10 15
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *At home*
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-12 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *8-9 1939* to *8-12 1939*
 I last saw him alive on *8-12 1939*. Death is said to have occurred on the date stated above, at *2:30 a.m.*
 The principal cause of death and related causes of importance were as follows:

Date of onset
3 da
2 1/2 yrs.

Peritonitis
 Other contributory causes of importance:
Post-gang Affliction +
Calcium albuminemia
Berria
 Name of operation *Removal of Gall Bladder* Date of *5-1-38*
 What test confirmed diagnosis? *R-26-56* Was there an autopsy? *Yes*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Mo*
 13. NAME *Stephen Campbell*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
 15. MAIDEN NAME *Emilia Langdon*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
 17. INFORMANT (ADDRESS) *P. J. Hume*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Brookfield Mo* DATE *Aug 12 1939*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Home of Snowden Brookfield Mo*
 20. FILED *Sept 1 1939* *J. M. Lucas* Local Registrar.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *0* Date of injury *0*, 19____
 Where did injury occur? *0* (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *0*
 Nature of injury *0*
 24. Was disease or injury in any way related to occupation of deceased? *No*
 If so, specify _____
 (Signed) *J. M. Lucas*, M. D.
 (Address) *Brookfield, Mo*

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.

RECEIVED

District Health Officer No. 11;

File Number 1939-1107

SEP 5 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

Homer Bowden

Licensed Embalmer No.....

P. O. Address

32975
Brookfield Mo

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.