

WHILE FLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 532 Primary Registration District No. 3027

Registrar's No. 95

1. PLACE OF DEATH:  
(a) County Macon  
(b) City or town Macon  
(c) Name of hospital or institution \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community all of her life years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Macon  
(c) City or town Macon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? no years.

3. (a) PRINT FULL NAME Louisa Brammer 656  
8. (b) If veteran, name war no 8. (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 9th year 1939 hour 3 minute 15 P.M.  
21. I hereby certify that I attended the deceased from June 6, 1939, to Oct 9, 1939; that I last saw her alive on Oct 9, 1939; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife H. J. Brammer 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased Oct. 14th 1879 (Month) (Day) (Year)

Immediate cause of death Carcinoma of colon & liver. Duration ?

8. AGE: Years 59 Months 11 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Macon Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Henry Rosemangle

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Goodbar

15. Birthplace Switzerland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Tracie W. Dean

(b) Address 204 So Ruby Macon Mo

17. (a) Burial (b) Date thereof 10/11/39 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director Stephens & Gooding  
(b) Address Macon Mo

19. (a) 11/6/39 (b) Deola Henderson (Date received local registrar) (Registrar's signature)

Major findings: Carcinoma involving colon, liver & glands  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. S. Honsinger (M. D. or other) MD  
Address Macon Mo Date signed Nov 3, 39

PHYSICIAN  
Underline the cause to which death should be charged statistically.

46

RECEIVED

District Health Officer No: 10

District File Number 11-39-1891

Date Filed NOV 8 1911

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 Chas. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon 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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

36619  
Do not use this space.

1. PLACE OF DEATH *Mason*  
 (a) County *Mason* Registration District No. *533*  
 (b) Township \_\_\_\_\_ Primary Registration District No. *3027* Registered No. *93-*  
 (c) City *Mason* (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 *Louise Brammer*  
 (a) Residence, No. \_\_\_\_\_ 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *M*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
 7. AGE YEARS MONTHS DAYS if LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*59 11 26*

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 *11/6/39* 19*39*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 9, 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 \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
*Carcinoma of Colon*  
*with liver*  
*Primary seat of malignancy*  
*was transverset colod*  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
*Carcinoma involving*  
*Colon, liver & glands*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? *H&E* 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 \_\_\_\_\_  
 (Signed) *E. S. Houshagen*, M. D.  
 (Address) *Mason* *Mo*

SUPPLEMENT

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