

WRITE PLAINLY—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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37660
Registrar's No. 9499

DEC 17 1939 791
Registration District No. 2003

Primary Registration District No. _____

1. PLACE OF DEATH: 2
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3438 Russell Blvd, Avlon Apts
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3438 Russell Blvd
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Danville S. Brackett 123
8. (b) If veteran, name war None 8. (c) Social Security No. None
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Marie W. Brackett 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased September 19 1867
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 5
year 1939 hour 5 minute 30 P M.
21. I hereby certify that I attended the deceased from Jan 1938
to Nov 5 1939
that I last saw him alive on Nov 5 1939
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>1</u>	<u>16</u>	hr. _____ min.

Immediate cause of death
Diverterculitis of Duodenum
Duration _____
Due to _____
Due to 123
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Sedalia Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Vice President
11. Industry or business Milling Industry
12. Name Dr James Brackett
13. Birthplace Cahokia Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Louise Subit
15. Birthplace Switzerland
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy Diverterculum of Duodenum
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Marie W Brackett
(b) Address 3438 Russell Blvd
17. (a) Burial (b) Date thereof Nov 8 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New S S Peter & Paul Wagoner Und Co
18. (a) Signature of funeral director _____
(b) Address 3621 Olive Street
19. (a) NOV 7 1939 (b) J F Bredich
(Date received local health officer) (Registrar's signature)

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 Edward Melbing (M. D. or other) M.D.
Address 4963 Fountain Date signed 11/6/39

Don H. H. Nelson
2-4 - P.M. 4963

2-4-63

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 Meville B. Proxmiter

Licensed Embalmer No. 3696

P. O. Address 3621 Olive St.

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.

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

37660
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... **791**
 (b) Township..... Primary Registration District No..... **1003**
 or
 (c) City..... (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

DARVILLE S. BRACKETT.

(a) Residence, No. **3438 Russell Blvd.** 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..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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 MONTHS DAYS 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 (NAME) (ADDRESS)

20. FILED **Jan. 8, 1940**

J. F. Brickett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov. 5, 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.....
 The principal cause of death and related causes of importance were as follows:

SUPPLEMENTARY

Date of onset

Other contributory causes of importance:

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.....

(Signed)....., M. D.

(Address).....

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.

WHILE (LARGE), WITH STRAIGHT INSTRUMENTS IS A P.P.E. INSTRUMENT RECORD

1 X16603

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.....

Licensed Embalmer No.....

P. O. Address.....

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.