

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. 297

Primary Registration District No. 3046 5414

1. PLACE OF DEATH:  
(a) County Franklin. St. John's Township.  
(b) City or town Washington, Mo. Rural #2.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3 mi. South of Washington, Highway 47  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
In this community 58 yrs. 0 mos. 18 das. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Elizabeth Broeker. 626  
3. (b) If veteran, name war X  
3. (c) Social Security No. X

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband Louis A. Broeker.  
6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased Nov. 17 1881  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>0</u>	<u>18</u>	hr. min.

9. Birthplace Washington, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife.

11. Industry or business X

MOTHER FATHER  
12. Name Valentine Huber.  
13. Birthplace Unknown Germany.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown.  
15. Birthplace Unknown.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Broeker  
(b) Address Washington, Mo. R. #2.

17. (a) Burial. (b) Date thereof Dec. 9, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington, Mo.

18. (a) Signature of funeral director Nieburg & Vitt, Inc. by  
(b) Address Washington, Mo.

19. (a) Dec. 7-1939 (b) H. A. May  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri. (b) County Franklin.  
(c) City or town Washington, Rural #2.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Highway 47.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 5th  
year 1934 hour 11 minutes 30 P. M.  
21. I hereby certify that I attended the deceased from November 28th, 1934 to Dec. 5-, 1934  
that I last saw her alive on Dec. 5-, 1934  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Atrophic Cirrhosis of Liver  
Duration Don't know  
Due to 12th

Other conditions abdominal tumor character  
(Include pregnancy within 3 months of death)  
unknown

PHYSICIAN  
Major findings:  
Of operations No operation  
Of autopsy None  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) X  
(b) Date of occurrence X  
(c) Where did injury occur? X  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? X

While at work? X (Specify type of place) (a) Means of injury X  
2710  
28. Signature H. A. May (M. D. certifier)  
Address Washington, Mo. Date signed 12/7/39

**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..... *Lester A. Witt* .....

Licensed Embalmer No. *3254*

P. O. Address. *Washington, D.C.*

**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.**