

FILED FEB 16 1940 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 135Primary Registration District No. 3010Registrar's No. 14

1. PLACE OF DEATH:

(a) County Cass
 (b) City or town Cassellton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Staten Clinic
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days (Specify whether
 In this community 77 yrs years, months or days)

3. (a) PRINT FULL NAME

Caleb Ross Brookover3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex

M5. Color or
race M6. (a) Single, widowed, married,
divorced _____

6. (b) Name of husband or wife

Fanny Pence6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased

7
(Month)19
(Day)1852
(Year)

8. AGE:

Years

Months

Days

If less than one day

87611

hr.

min.

9. Birthplace

Brown Co
(City, town, or county)Ohio
(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Aceal Brookover

13. Birthplace

Marysville Ky
(City, town, or county)Ky
(State or foreign country)

14. Maiden name

Ashie Johnston

15. Birthplace

Marysville Ky
(City, town, or county)Ky
(State or foreign country)

16. (a) Informant's own signature

William Murphy

(b) Address

Wakenda Mo17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof

2-1-40
(Month) (Day) (Year)

(c) Place: burial or cremation

Oak Hill Cem

18. (a) Signature of funeral director

Willis Marshall

(b) Address

Cassellton Mo19. (a) 1-31-40
(Date received local registrar)(b) John Haskins
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
 (c) City or town Cassellton Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 214 South Virginia St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 30
 year 1940 hour 3 pm minute _____ M.

21. I hereby certify that I attended the deceased from Jan 25/40
 _____, 19____, to Jan 30, 19____
 that I last saw him alive on Jan 30, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death

Left lobe pneumonia
followed by right
lobe pneumonia
 Due to _____
 Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

4 da.

PHYSICIAN

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) _____
 (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?

131. While at work? _____

28. Signature W. Hamilton M. D. or other _____
 Address Cassellton Mo Date signed Jan 30

WHILE FILLING IN USE INK—MAKE A PERMANENT RECORD

19381

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.

828

RECEIVED
District Health Officer No. 8,
District File Number
Date Filled 1/13/46

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 myself

....., Registered Apprentice No.

working under my personal supervision.

Signed R. M. Maxwell

Licensed Embalmer No. 25-25-

P. O. Address Carrington 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1958
Registrar's No. 14

Registration District No. 135-

Primary Registration District No. 3010

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Carroll
(b) City or town: Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(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. (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Caleb Ross Brookover
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex: m
5. Color or race: w
6. (a) Single, widowed, married, divorced: wed
6. (b) Name of husband or wife.
6. (c) Age of husband, or wife, if alive. years.
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days 11 If less than one day min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State. (b) County.
(c) City or town. (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. years.

20. DATE OF DEATH: Month Jan day 20 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death: Left Hemiplegia followed by right Hemiplegia
Due to: cerebral hemorrhage
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations \$200
Of autopsy.

Duration
PHYSICIAN
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).
(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: R. Hamilton Stator (M. D. or other)
Address: Carrollton Mo Date signed

SUPPLEMENTARY

