

FILED MAR 11 1940

State File No. _____

Registration District No. 175

Primary Registration District No. 6020-A

Registrar's No. 18

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" add name of township)
(c) Name of hospital or institution: Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 60 yrs
years, months or days)

8. (a) PRINT FULL NAME Elizabeth Braun

3. (b) If veteran, name war ✓ 3. (c) Social Security No. no.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Carl Braun 6. (c) Age of husband or wife if alive decd years

7. Birth date of deceased June 2 1854
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 11 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business _____

12. Name Peter Mell

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

14. Maiden name Sophia Hofer

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

16. (a) Informant's own signature Chas P. Braun

(b) Address Farmington Mo.

17. (a) Burial (b) Date thereof Feb. 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran

18. (a) Signature of funeral director Meinders Mud Co

(b) Address Farmington Mo.

19. (a) Feb. 15, 1940 (b) N. W. Hawkins
(Date received local registrar) (Registral's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois
(c) City or town Farmington
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13
year 1940 hour 1 minute 45 a. M.

21. I hereby certify that I attended the deceased from Feb. 9
1940 to Feb. 13, 1940

that I last saw her alive on Feb. 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of neck of left femur
Terminal hypoxia
Due to premature

Due to 18 15

Other conditions Sensitivity; Arterio-
(Include pregnancy within 3 months of death)
sclerotic Heart Dist & general

Major findings: Arteriosclerosis

Of operations _____
Of autopsy 1

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 Dr. Richard Couch (M. D. or other) Dr. D.
Address Farmington, Mo. Date signed 2-13-40

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

FORM 17-39
REV. 5-17-39
U. S. G. P. 1 X19511

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.

MAINTAINED RESERVED FOR BINDING

1942
MS

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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. 4237
working under my personal supervision.

Signed John A. Sanders
.....
Licensed Embalmer No. 2238

P. O. Address Farmington, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **7977**

Registration District No. **775**

Primary Registration District No. **6020 A**

Registrar's No. **18**

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

1. PLACE OF DEATH

(a) County **St. Francois**

(b) City or town **Bonne Terre**
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Elizabeth Brown**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

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	Months	Days	If less than one day
	85	8	11	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **7** day **13**
year **1940** hour _____ minute _____ M.

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

Immediate cause of death **Fracture of neck of left femur**
terminal bronchitis
Due to **Pneumonia**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **Senility arteriosclerotic heart disease and general arteriosclerosis**

Of autopsy **arteriosclerosis**

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) **Accident**

(b) Date of occurrence **Feb. 9, 1940**

(c) Where did injury occur? **Dr. Rm. St. Francois Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)

While at work? **No** (e) Means of injury **Fall**

23. Signature **F. Richard Cronch** (other)
Address **Farmington Mo.** (other)

