

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 9993

APR 17 1940

Registration District No. 27Primary Registration District No. 3001Registrar's No. 62

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Green Castle
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Green Castle
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 hours (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Laura Senneal Brinson

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nora 6. (c) Age of husband or wife If alive _____ years
 7. Birth date of deceased Oct 8 1888
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>5</u>	<u>2</u>	hr. _____ min.

9. Birthplace State of Mo. (City, town, or county) (State or foreign country)10. Usual occupation Road and railway11. Industry or business Farmer & trader12. Name James A. Brinson13. Birthplace State of Mo. (City, town, or county) (State or foreign country)14. Maiden name Laura Senneal Brinson15. Birthplace State of Mo. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Nora S. Brinson(b) Address Green Castle, Mo.17. (a) Burial (b) Date thereof March 12-40 (Month) (Day) (Year)(c) Place: burial or cremation Union Burial18. (a) Signature of funeral director W. J. Brinson(b) Address Green Castle, Mo.19. (a) March 12 40 (b) Spencer J. Talley (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
 (c) City or town Green Castle, Mo. (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 March day 10th year 1940 hour 4 minute 15 P. M.21. I hereby certify that I attended the deceased from March 9, 1940, to March 10, 1940; and that I last saw him alive on March 10, 1940; and that death occurred on the date and hour stated above.Immediate cause of death Generalized peritonitis Duration 24 hrsDue to Perforated duodenal ulcer 24 hrsDue to Duodenal ulcer 11 1/2 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations Perforated duodenal ulcer
anterior superior portion exposed
 Of autopsy None

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? _____

3 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature George E. Linn, MD (M. D. or other) _____
 Address Green Castle, Missouri Date signed 3-10-40

RECEIVED

District Health Officer No. 10

District File Number 4-40-152

Date Filed April 9, 1940

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.....

W D Haines....., Registered Apprentice No.....
working under my personal supervision.

Signed W D Haines.....

Licensed Embalmer No. 849.....

P. O. Address Belmont City 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

State File No. **9993**

Registration District No. **1**

Primary Registration District No. **1**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Furnessville**
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **Levio Samuel Miser**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

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
34 5 2 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 (City, town, or county) (State or foreign country)
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) **Dec 18, 1946** (b) **Spencer L. Freeman** (Registrar's signature)
(Date received local registrar)

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 **3** day **10**
year **1946** 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 _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
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) _____
(c) Means of injury _____
23. Signature **Geo E. Swan** (M. D. or other) _____
Address **Furnessville** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PERMANENT RECORD
WRITE PLAINLY—USE UNFADING BLACK INK

SUPPLEMENTAL COPY

S-9993 1940