

Registration District No. 625

Primary Registration District No. 3031

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Marionville, MO
(If outside city or town limits, write "RURAL", and name of township)
(c) Name of hospital or institution:
St. Francis Hospital
(If using hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
(Specify whether
In this community _____
years, months or days) 6

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Mrs. Marguerite Brooks

8. (b) If veteran, name war _____ (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Dr. W. W. Brooks (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 23 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business at home

12. Name James M. Boulevard

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

14. Maiden name Camelia Doe

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

16. (a) Informant J. V. Boulevard
(b) Address 882 W. Chestnut

17. (a) burial (b) Date thereof 3/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stonberry, MO

18. (a) Signature of funeral director W. H. Phillips
(b) Address Stonberry, MO

19. (a) 3/15/40 (b) Mattie C. Clardy
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month March day 14
year 1940 hour 10 minute A M.

21. I hereby certify that I attended the deceased from Feb. 5, 1940 to March 14, 1940;
that I last saw her alive on March 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cause of Rt Breast Rt Chest wall and Rt. Arm

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 _____
Where did injury occur? _____ (City or town) (County) (State)
(c) Did injury occur in or about home, on farm, in industrial place, in public place?
5-6 _____ (Specify type of place)
While at work? _____ (2) Means of injury _____

23. Signature W. R. Jackson (M. D. or other) _____
Address Marionville, Mo. Date signed 3/14/40

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

57

RECEIVED
District Health Officer No. 111
District File Number 440-604
Date Filed APR 16 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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed Leroy F. Phillips

Licensed Embalmer No. 1898

P. O. Address Storby Md

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. **11877**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **625-**

Primary Registration District No. **3031**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Nodaway
 (b) City or town Marquillo
(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 years, months or days)
 In this community _____

3. (a) PRIN FULL Mrs. Marquerite Briscoe
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 79 Months 7 Days 21
 If less than one day _____ hr. _____ 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) _____ **(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 Mar day 14
 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 Cause of death
Heart of chest and
at arm

Due to Pneumonia in R. Chest

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

Major findings:
 Of operations _____
 Of autopsy _____

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? _____ **(e) Means of injury** _____

23. Signature W. P. Jackson (M. D. or other) _____
Address Marquillo **Date signed** _____

SUPPLEMENTAL

11877 (1940)