No. 2
1-10-39
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14309

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 396

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

1. PLACE OF DEATH:

(a) County Buchannan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: At Home 2223½ Locust (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) About 15 or 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) Missouri (b) County Buchannan

(c) City or town Saint Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 2223½ Locust (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME Carl Braden

8. (b) If veteran, name war MO

3. (c) Social Security No. MO

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cornelia Braden

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased 6 (Month) 6 (Day) 1888 (Year) (1888)

8. AGE: Years 51 Months 8 Days 29 If less than one day hr. min.

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

10. Usual occupation Comon Laborer

11. Industry or business Laborer

FATHER
12. Name William Braden
13. Birthplace Ray County Missouri. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Graham Mollie
15. Birthplace Ray County Missouri. (City, town, or county) (State or foreign country)

16. (a) Informant Cornelia Braden

(b) Address 2223 ½ Locust St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/ 8/1940 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Ramsey's Mortuary.

(b) Address 1602 Messanie St.

19. (a) April 8 1940 (Date received local registrar) (b) H J Nettlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5 year 1940 hour 3 P.M. minute M.

21. I hereby certify that I attended the deceased from Jan, 1939, to Apr 5, 1940, that I last saw him alive on Apr 3, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary T.B.	5 yrs
Due to	
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? (Specify type of place)

85 While at work? (e) Means of injury

23. Signature J M Allaman (M. D. or other)

Address Central Bldg Date signed 4/6/40

(Licensed Embalmer's Statement on Reverse Side)

June 6 84

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 I. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.