

JUL 12 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22177

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. 48

1. PLACE OF DEATH:  
(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mc Laney Hosp  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution 11 days  
(Specify whether  
In this community 70  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Linn  
(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 274 E. Brooks  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Nellie E. Hannan  
3. (b) If veteran, name war WW  
3. (c) Social Security No. None

20. DATE OF DEATH: Month June day 11  
year 1940 hour 3 minute A. M.

4. Sex Female 5. Color or race White 6. (a) (Single) widowed, married, divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 22 1877  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 1939 to June 11 1940  
that I last saw her alive on June 10 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death peritonitis Duration 7 days

8. AGE: Years 62 Months 8 Days 19 If less than one day hr. \_\_\_\_\_ min.

Due to Infection of gall bladder 14 mos.

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

Due to Surgery on gall bladder was done June 2 1940

10. Usual occupation \_\_\_\_\_  
11. Industry or business Publicist  
12. Name Charles M. Hannan  
13. Birthplace Richmond Va  
(City, town, or county) (State or foreign country)  
14. Maiden name Mildred Purdin  
15. Birthplace Purdin Mo  
(City, town, or county) (State or foreign country)

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

16. (a) Informant's own signature Nellie E. Hannan  
(b) Address Brookfield Mo  
17. (a) Brookfield (b) Date thereof June 15 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Brookfield  
18. (a) Signature of funeral director Walter Ballin  
(b) Address Brookfield Mo  
19. (a) June 13 1940 (b) W. B. Simpson  
(Date received local registrar) (Registrar's signature)

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? 445  
(Specify type of place) While at work? \_\_\_\_\_ (Specify means of injury) \_\_\_\_\_  
23. Signature W. B. Simpson (M.D. or other) MD  
Address Brookfield Mo Date signed 6/11/40

WHILE I REMAIN USE WRITING BLACK INK—MAKE A PERMANENT RECORD

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

**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.....

*L. W. Collins*

Licensed Embalmer No.....

*11444*

P. O. Address.....

*Brookfield, 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.**

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Registrar's No. \_\_\_\_\_

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

1. PLACE OF BIRTH:

(a) County Linn  
(b) City or town Branfield  
(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 Nellie E. Hannan

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, divorced, 8 married

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  
62 8 19 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 (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 11 year 1940 ho \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Peritonitis Duration \_\_\_\_\_

Infection of gallbladder  
Due to Abscess of gallbladder  
no stones  
Surgery on gallbladder  
was done June 2nd 1940

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 177  
Of operations Abscess gallbladder  
requiring drainage  
Of autopsy no stones.

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 W. B. Simpson (or Dr. or other) \_\_\_\_\_  
Address Branfield Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

