

Registration District No. 508

Primary Registration District No. 5675

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Jackson 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 2
In this community 2 1/2 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME George R. Brugh 620
3. (b) If veteran, name war Civil 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 Ada J. Brugh
6. (c) Age of husband or wife if alive 86 years
7. Birth date of deceased Feb. 24 1846
(Month) (Day) (Year)

8. AGE: Years 94 Months 3 Days 20
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____
12. Name Maxial Brugh
13. Birthplace Unknown Virginia
14. Maiden name Elizabeth Rader
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Don Allen Brugh
(b) Address Nebo mo R 7 P H 5

17. (a) Burial (b) Date thereof June 16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lock Springs, Mo.

18. (a) Signature of funeral director James Gordon
(b) Address Chillicothe Mo.

19. (a) 6-15-40 (b) J. M. W. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Jackson Township
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1940 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from June 1 1940 to June 14 1940
that I last saw him alive on June 1 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration
Due to Senility

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? 943

While at work? _____ (Specify type of place) (e) Means of injury _____

28. Signature [Signature] (M. D. or other) _____
Address Chillicothe Mo. Date signed 6/15/40

PHYSICIAN
Underline the cause to which death should be charged statistically

I 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.

WHITE PRINT—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 11,

District File Number

Date Filed

7-50-116 ✓
JUL 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1870

P. O. Address.....

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.