

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33351

State File No.

Registration District No. 865

Primary Registration District No. 6149

Registrar's No. 29

1. PLACE OF DEATH

(a) County Texas
(b) City or town Rural Sherman
(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 2
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mt (b) County Texas
(c) City or town Rural Sherman
(If outside city or town limits, write "RURAL")
(d) Street No. Near Hickling
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day Sept
year 1940 hour 6 a minute _____ M.
21. I hereby certify that I attended the deceased from June 40
Sept 18, 1940, to _____, 19____;
that I last saw her alive on Sept 16, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death mal develop
Born before cert
Duration _____
Due to _____

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
159

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? no
While at work _____ (Specify type of place)
(e) Means of injury _____
23. Signature Leslie Kaudal (M. D. or other) MD
Address Lickings Date signed 9-23-40

3. (a) PRINT FULL NAME Bonnie Gene Brum

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

4. Sex Female 5. Color or race wh 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased June 19 (Month) 40 (Day) (Year)

8. AGE: Years _____ Months 3 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Lickings Mt (City, town, or county) 0 (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

12. Name John Brum

13. Birthplace Texas Mt (City, town, or county) 0 (State or foreign country)

14. Maiden name Marion Green

15. Birthplace South Tree Tex (City, town, or county) (State or foreign country)

16. (a) Informant John Brum

(b) Address Lickings

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/19/40 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem

18. (a) Signature of funeral director John Brum

(b) Address Lickings

19. (a) 9/18/40 (Date received local registrar) (b) [Signature] (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No 5,

District File Number 10401045

Date Filed

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.....

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, fact should be so stated above.