

700 FEB 10 1941

MISSOURI STATE BOARD OF HEALTH/
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1693
Do not use this space.

1. PLACE OF DEATH

(a) County Bates Registration District No. 50
 (b) Township Shawnee Primary Registration District No. 5089 Registered No. 8
 (c) City Adrian (d) Street No. 7 St. 7
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 10 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. 0

2. PRINT FULL NAME Daniel C. Brake

(a) Residence, No. 0 St. 0
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edith Brake
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 3-1870
 7. AGE YEARS 70 MONTHS 10 DAYS 27 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wright Co Mo

FATHER 13. NAME Marck Brake

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Miss Mance

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs Edith Brake
Adrian Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Grove Springs DATE Jan Feb 2 '41
Removal

19. FUNERAL DIRECTOR (ADDRESS) Frank C. Wilkinson
Adrian Mo

20. FILED Feb 7 1941 Anna L. Culver
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 31 1941

22. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1941, to Jan 31, 1941.
 Last saw him alive on Jan 29, 1941. Death is said to have occurred on the date stated above, at 2:45 P.M.
 The principal cause of death and related causes of importance were as follows:

Coronary thrombosis

Other contributory causes of importance: arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? ✓ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) Dr. A. J. Latham J. M. D.
Adrian Mo
 53 (Address)

Date of onset
94

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

RECEIVED

District Health Officer No. 7,

District File Number 2-41-327

Date Filed 2-12-41

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Keith Jackson

Licensed Embalmer No. 3954

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.)

No. 2B
2-21-40
1 722559

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 1693

Registration District No. 50

Primary Registration District No. 5089

Registrar's No. 8

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

1. PLACE OF DEATH
(a) County Bates
(b) City or town Shawnee
(c) Name of hospital or institution: Home
(If outside city or town limits, write "RURAL" and name of township)
(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)

3. (a) PRINT FULL NAME Daniel C. Brake
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 27
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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 28 1941 (b) Nina S. Culver
(Date received local registrar) (Registrar's signature)

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

20. DATE OF DEATH Month Jan day 31
year _____ hour _____ 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 _____

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 _____
(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)

(c) Means of injury _____

23. Signature A. S. Carlson (Dr. D. or other)

Address Adrian Mo Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-1693