

Registration District No.

274

Primary Registration District No.

4063

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Lilburn, Mo.  
(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 1 (Specify whether  
In this community 3 yrs. years, months or days)

3. (a) PRINT FULL NAME CHARLIE BROOKS.

3. (b) If veteran, name war Worlds War 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Emma Brooks. 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Aug. 6, 1890  
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 13 If less than one day  
hr. min.

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

10. Usual occupation Labour

11. Industry or business

12. Name Robert Brooks

13. Birthplace Louisiana  
(City, town, or county) (State or foreign country)

14. Maiden name Fussy Allie Pate

15. Birthplace Louisiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Emilia Brooks

(b) Address Lilburn, Mo.

17. (a) Burial (b) Date thereof 1-22-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wadell, Mo.

18. (a) Signature of funeral director Travis Shelby

(b) Address East Prairie, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Lilburn, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19th. year 1941 hour 7:45 minute AM.

21. I hereby certify that I attended the deceased from 1-18-41 to 1-19-41

that I last saw him alive on 1-19-41 and that death occurred on the date and hour stated above.

Immediate cause of death Obtained Pneumonia Duration 2 wks.

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? \_\_\_\_\_

537 (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury

23. Signature J. W. Edmondson (M. D. or other) \_\_\_\_\_

Address New Madrid, Mo. Date signed 1-31-41

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

72  
2  
0

72  
2  
0

108

RECEIVED

District Health Officer No. 2

District File Number 141-263

Date Filed 2/14/41

APR 18 1958

**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.....

working under my personal supervision.

Registered Apprentice No. ....

Signed

*Francis Shelby*

Licensed Embalmer No. ....

2726

P. O. Address

East Prairie 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3532

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 274

Primary Registration District No. 4063

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

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town \_\_\_\_\_  
(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 Charlie Brooks

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 \_\_\_\_\_

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 50 Months 5 Days 13 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) \_\_\_\_\_ (b) \_\_\_\_\_ (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.

3. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 19 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Bilateral Pneumonia  
bronchial

Due to \_\_\_\_\_

Due to \_\_\_\_\_ 107

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? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration 2 wks  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

R

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35-32

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 274

Primary Registration District No. 4063

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: New Madrid  
 (b) City or town: Lilbourn Mo  
 (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: \_\_\_\_\_ (Specify whether)  
 In this community: 3 yr years, months or days

3. (a) PRINT FULL NAME: Charlie Brooks  
 (b) If veteran, name war: Worlds War  
 (c) Social Security No.: none

4. Sex: m 5. Color or race: w  
 6. (a) Single, widowed, married, divorced: m  
 (b) Name of husband or wife: Emma Brooks  
 (c) Age of husband, or wife, if alive: 36 years  
 7. Birth date of deceased: Aug 4 (Month) (Day) 1895 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>5</u>	<u>13</u>	hr. min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

12. Name: Robert Brooks  
 13. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 14. Maiden name: Lily Alice Tate  
 15. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant: Emma Brooks  
 (b) Address: Lilbourn Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-22-1944 (Month) (Day) (Year)  
 (c) Place: burial or cremation: Wardell Mo

18. (a) Signature of funeral director: Travis Shelby  
 (b) Address: East Prairie Mo

19. (a) Apr 20/44 (Date received local registrar) (b) E. E. Jones (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 Jan day 19  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death: Bilateral Pneumonia Duration \_\_\_\_\_

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?  
 \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature: Dr. Edmondson (M. D. or other) \_\_\_\_\_  
 Address: New Madrid Mo Date signed \_\_\_\_\_

STIPULATED TEMPORARILY