

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9931**
Registrar's No. **15**

Registration District No. **4** Primary Registration District No. **4507**

1. PLACE OF DEATH:
(a) County **Audrain**
(b) City or town **Farber**
(c) Name of hospital or institution: **1**
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Audrain**
(c) City or town **Farber**
(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. **0** years.

3. (a) PRINT FULL NAME **EMMA MARANDA BRANDON**
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **3rd**
year **1941** hour **5** minute **A.M.**
21. I hereby certify that I attended the deceased from **April 1**, 19**41**, to **April 3**, 19**41**
that I last saw her alive on **April 3**, 19**41**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **M. E. Brandon**
6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **August 28 1879**
(Month) (Day) (Year)

Immediate cause of death **Starvation**
Due to **occlusion of Duodenum**

8. AGE: Years **62** Months **7** Days **6** If less than one day hr. min.

Due to **Ulcer of Duodenum**
Other conditions **cholecystitis with gall stones**

9. Birthplace **Pike County Mo**
(City, town, or county) (State or foreign country)

Major findings: **11/10**
Of operations _____
Of autopsy **Above named conditions**

11. Industry or business _____
12. Name **James Beathford**
13. Birthplace **Pike Co Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Emilia Thompson**
15. Birthplace **Howard Co Missouri**
(City, town, or county) (State or foreign country)

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? **Y**

16. (a) Informant's own signature **M. E. Brandon**
(b) Address **Farber Missouri**
17. (a) **Burial** (b) Date thereof **Apr 5 '41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Farber Mo**

(Specify type of place) _____
(e) Means of injury _____
28. Signature **R. P. Brize** (M. D. or other) **DO.**
Address **Ladonia Mo.** Date signed **4-5-41**

18. (a) Signature of funeral director **J. S. Matlock**
(b) Address **Vandalia Missouri**
19. (a) **Apr 5 '41** (b) **R. Lee Albert**
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 10
Case Number 4-41-844
Date Filed APR 19 1941

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 W B Waters

Licensed Embalmer No. ~~3321~~ 4169

P. O. Address Union Station 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.