

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 24927
Registrar's No. 97

11 1941

on District No. 218Primary Registration District No. 3015

1. PLACE OF DEATH:

- (a) County Casper
 (b) City or town Bobnville Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph
 (If not in hospital or institution, write street number or location)
 (d) Length of stay in hospital or institution 0 (Specify whether

In this community
years, months or days8. (a) PRINT FULL NAME Henry Brooks8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex M 5. Color or race W. 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 Feb. 23 1880
 (Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days 2 If less than one day _____ hr. _____ min.9. Birthplace Warren Co Mo
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business ✓

12. Name James Brooks
 13. Birthplace Indiana
 (City, town, or county) (State or foreign country)
 14. Maiden name Katherine Logan
 15. Birthplace Warren Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs G E Schenck(b) Address New Franklin Mo17. (a) Burial (b) Date thereof 7/27/41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Wright City Cem18. (a) Signature of funeral director Woburn B & Co(b) Address Wright City Mo19. (a) 7-25-41 (b) D Hooper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County 169
 (c) City or town Wright City
 (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. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1941 hour 12:30 minute A M.21. I hereby certify that I attended the deceased from Apr 15
1941, to July 25, 1941.
that I last saw him alive on July 24, 1941.
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma Duration Sept 1940Due to Carcinoma fingers
Right handDue to _____
Other conditions 50
(Include pregnancy within 3 months of death)Major findings: amputation of arm
Of operations Nov 1940

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) (d) Means of injury _____

23. Signature L. L. Chamberlain (M. D. or other) ✓
Address New Franklin Mo Date signed July 25-41

Date Filed 8-6-41
District File Number
District Health Officer No. 8

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 Julius J. Nieburg
Licensed Embalmer No. 33766
P. O. Address Wright City, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24927
Registrar's No. 91

Registration District No. 218

Primary Registration District No. 3015

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

1. PLACE OF DEATH:

(a) County Coopers
(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph
(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:

(b) State Mo (b) County _____
(c) City or town Wright city
(If outside city or town limits, write "RURAL")
(d) Street No. Gen. Del- (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Henry 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 _____ years

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

8. AGE: Years 71 Months _____ Days _____ If less than one day _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month _____ Day _____ Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

5-24927

Joseph H. Dill