DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25078

Registrar's District No. AUG 15 1941

Primary Registration District No. 2001

Registrar's No. 536

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sfd. Baptist Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 0 (Specify whether years, months or days)
In this community 40 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Wright
(c) City or town Hartville (Rural) (If outside city or town limits, write "RURAL")
(d) Street No. 8 Mi. North West (If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years

3. (a) PRINT FULL NAME PAUL KILLIAN BROOKS
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex M. 0
5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Martha Brooks
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Aug. (Month) 22 (Day) 1879 (Year)

8. AGE: Years 61 Months 10 Days 10 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) North Carolina (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name William Brooks
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant's own signature Martha Brooks
(b) Address Hartville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-41 (Month) (Day) (Year)
(c) Place: burial or cremation Little Creek Cem.
18. (a) Signature of funeral director Ellis L. Boulding
(b) Address Norwood Mo.
19. (a) 7-5-41 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1941 hour 10 o'cl minute P. M.
21. I hereby certify that I attended the deceased from June 25, 1941, to July 2, 1941, that I last saw him alive on July 2, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardio-vascular renal disease	2 yr
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Guy D. Calloway (M. D. or other) M.D.
Address Springfield Mo. Date signed 7/7/41

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Ella J. Bouldin

Licensed Embalmer No. 1949

P. O. Address Norwood V

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. No. 2B
—8-21-41
P I X29288

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

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No. 25078

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 536

1. PLACE OF DEATH

(a) County: Greene

(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: (Specify whether years, months or days)

In this community: 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Wright

(c) City or town: Hartsville Rural (If outside city or town limits, write "RURAL")

(d) Street No.: 8 mi N.W. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Paul K 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: M

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 | Months | Days | If less than one day: hr. min.

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

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 27 year 1941 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.

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: (M. D. or other)

Address: Date signed:

SUPPLEMENTARY

S-25078