No. 2
13-40
17-39
59

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28428

State File No. 317

FILED SEP 6 1941

Registration District No. 3-18

Primary Registration District No. 4206

Registrar's No. 11704

1. PLACE OF DEATH:
(a) County: Henry
(b) City or town: Brownington (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: IN Brownington (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 4 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Henry 042 17 6
(c) City or town: Brownington (If outside city or town limits, write "RURAL")
(d) Street No.: IN Brownington (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Mary A Whittenbraker
3. (b) If veteran, name war: ____
3. (c) Social Security No.: ____
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband ~~or wife~~: Freq Wittenbraker
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: May (Month) 26 (Day) 1863 (Year)

8. AGE: Years 78 | Months 2 | Days 26 | If less than one day: ____ hr. ____ min.

9. Birthplace: McLain Co (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____

FATHER
12. Name: Julius F Lytle
13. Birthplace: Lexington (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Menerva J Masley
15. Birthplace: ____ (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant: Freq Whittenbraker
(b) Address: Brownington Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-26-41 (Month) (Day) (Year)
(c) Place: burial or cremation ✓
18. (a) Signature of funeral director: Freq E Wilkinson
(b) Address: Clinton Mo
19. (a) Aug-27-41 (Date received local registrar) (b) C. D. Taylor M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22 year 1941 hour 6 minute 00 A.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: Acute Indigestion with chronic Myocarditis — complication
Due to: ____
Due to: ____
Other conditions (Include pregnancy within 3 months of death): G 3 P
Major findings: Of operations ____ Of autopsy ____

Duration

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: J J Russell (M. D. or other)
Address: ____ Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 9-41-1604
Date Filed 9-3-41

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 Fred W. Wekenson

Licensed Embalmer No. 2478

P. O. Address Clinton M

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, fact should be so stated above.

No. 2B
I—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28428

Registration District No. 348 Primary Registration District No. 4206 Registrar's No.

1. PLACE OF DEATH:

(a) County: Henry

(b) City or town: Grainington (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 years, months or days) In this community: 4 yrs

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Mary A. Wittenbraker

3. (b) If veteran, name war: 3. (c) Social Security No.

4. Sex: F 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: May (Month) 26 (Day) 1863 (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: Maplewood Cemetery

18. (a) Signature of funeral director

(b) Address

19. (a) Aug 25-41 (Date received local registrar) (b) C. D. Taylor M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: aug day: 24 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)

(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

SUPPLEMENTARY