DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28908

Registration District No. 919 SEP 15 1941

Primary Registration District No. 5793a

Registrar's No. 19

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

1. PLACE OF DEATH:

(a) County Morgan

(b) City or town Rural Hawcreek Tp.
(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 2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan
(c) City or town Rural Hawcreek
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Sam C. Brunnemer

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased August (Month) 9 (Day) 1888 (Year)

8. AGE: Years 53 Months 0 Days 15 If less than one day ____ hr. ____ min.

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

10. Usual occupation Farm Laborer

11. Industry or business General Farming

FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) ____ (State or foreign country)

Informant not living, no relatives or friends to get any questions. Most information given by friends.

16. (a) Informant L. E. Brockman
(b) Address Versailles Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 27-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Nevada.

18. (a) Signature of funeral director Raop & Stevinson
(b) Address Stover, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August Day 25th year 1941 hour Unknown minute ____ M.

21. I hereby certify that I attended the deceased from Found dead August 25, 1941, 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 Organic heart disease ✓ — 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)
(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 L. E. Brockman (M.D. or other)
Address Versailles Mo. Date signed Aug 25-41

(Licensed Embalmer's Statement on Reverse Side)

Morgan Co

OCT 3 0 1941

RECEIVED
District Health Officer No. 7,
District File Number 9-41-1656
Date Filed 9-11-41

MAR 19 1951

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 Earl Rapp

Licensed Embalmer No. 3458

P. O. Address Stover, Mo.

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

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
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. 28 908

Registration District No. 919 Primary Registration District No. 5793A Registrar's No.

1. PLACE OF DEATH:

(a) County: Morgan

(b) City or town: Rural
(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

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: Sam C. Brunnemer

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: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Aug (Month) 9 (Day) 1888 (Year)

8. AGE: Years 53 Months 0 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Sept 10-1941 (Date received local registrar) (b) Wm L. Rippeyger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2 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.

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:

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(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