DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 6 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

13780

State File No. 96

Primary Registration District No. 1001

Registrar's No. 439

1. PLACE OF DEATH:

(a) County Buchanan,

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

(c) Name of hospital or institution:
Missouri Methodist Hospital,
(If not in hospital or institution, write street number or location)

(d). Length of stay: In hospital or institution 3 days, (Specify whether
In this community 11 years,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan 11

(c) City or town Saint Joseph, 1
(If outside city or town limits, write "RURAL")

(d) Street No. 102½ North 2nd. Street, 7
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Nelson Horatio Brough,

3. (b) If veteran, name war None,

3. (c) Social Security No. 491-09-3054

4. Sex Male

5. Color or race White

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 August 10, 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
53	8	12	hr. min.

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

10. Usual occupation Cook,

11. Industry or business Hotel,

FATHER
12. Name Jake Brough,
13. Birthplace Unknown, 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Unknown,
15. Birthplace Unknown, 9
(City, town, or county) (State or foreign country)

16. (a) Informant Welfare Board Records,
(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof 4/29/42.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery,

18. (a) Signature of funeral director Heaton - Belsole & Bowman Funeral
(b) Address 319 So. 10th Str. - Home

19. (a) 4-29-42 (b) Rose Herzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd.
year 1942, hour 10:00 minute 25 a.m.

21. I hereby certify that I attended the deceased from 4-19-42, 19..., to 4-22, 1942
that I last saw him alive on 4-22, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Uremia
Due to Hemiplegia
Malignant hypertension
Due to

Other conditions
(Include pregnancy within 3 months of death)

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 0

23. Signature [signature] (M. D. or other) MD

Address St. Joseph Mo Date signed 4-28-42

1233 (Licensed Embalmer's Statement on Reverse Side)

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 4-22

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm E. Immerfeel

Licensed Embalmer No. 3007

P. O. Address 319 So 10 Mosy

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

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

V. S. No. 2B
10M—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. 13780

Registration District No. ..... Primary Registration District No. 1001 Registrar's No. .....

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: Mo Methodist Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 11 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(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 Nelson H. Brough

3. (b) If veteran, name war .....

3. (c) Social Security No. 491-09-3034

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Aug 10 (Month) — 1883 (Day) (Year)

8. AGE: Years 53 Months 8 Days 12 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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 22 year 1942 hour 10 minute 23 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 Cerebral hemorrhage Uremia

Due to R. hemiplegia Malignant Hypertension

Due to Chronic Nephritis.

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131b

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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY