

FILED JUL 15 1942 619

Registration District No.

Primary Registration District No. **4370**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Nodaway**
(b) City or town **Clearmont**
(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)
In this community **19 years**
years, months or days

3. (a) PRINT FULL NAME **Della May Brandt**

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 **W**

6. (b) Name of husband or wife **Charles Brandt** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **December 29 1877**
(Month) (Day) (Year)

8. AGE: Years **64** Months **5** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **Marion Co. Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Homemaker**

11. Industry or business _____

MOTHER FATHER

12. Name **Amos Harriett** 9

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

14. Maiden name **Elysa LeGrand** 9

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

16. (a) Informant **Mrs R. H. Sparks**

(b) Address **Blanchard Iowa**

17. (a) **Burial** (b) Date thereof **June 15-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clearmont Mo**

18. (a) Signature of funeral director **Pine Funeral Home**

(b) Address **Marionville Mo**

19. (a) **July 19** (b) **Mrs. W. E. Carpenter**
Date received local registrar (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Nodaway**
(c) City or town **Clearmont**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June 17** day _____
year **1942** hour **7** minute **P** 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 _____

Cerebral thrombosis **sudden**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy **Cerebral thrombosis**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. R. Jackson** (M. D. or other) _____

Address **Marionville, Mo** Date signed **6-20-42**

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

74
6
0

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 Clem M Price
Licensed Embalmer No. 1822
P. O. Address Marywell, 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, fact should be so stated above.