

21916

FILED JUL 20 1942 34  
Registration District No. \_\_\_\_\_

Primary Registration District No. 58-44 4580

Registrar's No. 21

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0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Astoria

(c) Name of hospital or institution: 1  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Oregon <sup>75</sup>

(c) City or town Astoria <sup>5</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clinta B. Brooks

3. (b) If veteran, ✓ name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1  
year 1941 hour 11 minute 05-6 M.

4. Sex Fe 1

5. Color or race W

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

6. (b) Name of husband or wife John D. Brooks

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased 12-1-1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 12 1941 to Oct 30 1941  
that I last saw h. W. alive on Sept 30 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 10 Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Pericardial Aneurysm (18 yrs) High Blood Pressure (20 yrs)

Due to Stenility

Due to \_\_\_\_\_

9. Birthplace Oregon Co. Mo-O  
(City, town, or county) (State or foreign country)

Other conditions 173a  
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Eli Bates

13. Birthplace Tenn-1  
(City, town, or county) (State or foreign country)

14. Maiden name Antonia Green

15. Birthplace Nor Carolina 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Richard Brooks

(b) Address Daryville - S.W. R.F.

17. (a) Burial (b) Date thereof 10-3-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Astoria Me

18. (a) Signature of funeral director Ray Carr

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Emol. Bentley  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 0

23. Signature W. O. Cooper (M. D. or other) MD  
Address Rayville Mo Date signed 10-1-41

PHYSICIAN  
Underline the cause to which death should be charged statistically.

1113

RECEIVED

District Health Officer No. 8,

District File Number 242270

Date Filed 7-17-42

**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: *Leo Carr*

Licensed Embalmer No. 2852

P. O. Address *Thayer W.*

**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.**