2330

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

FEB 9 1943

Registration District No. 133 Primary Registration District No. 5483 Registrar's No. 4

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

1. PLACE OF DEATH:
(a) County Harrison
(b) City or town Bethany Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Home 5
(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 Mo (b) County Harrison
(c) City or town Bethany Twp
(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 William C. Brover
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced 3 divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 7 (Day) 1864 (Year)

8. AGE: Years 78 Months 11 Days 5 If less than one day hr. min.

9. Birthplace Seymour (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Canton Brover
13. Birthplace Iowa (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. John Cain
(b) Address Centerville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14 1943 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Lone Cemetery
18. (a) Signature of funeral director Joe E. Wheeler
(b) Address Bethany Mo.
19. (a) Jan. 14-1943 (Date received local registrar) (b) Zola M. Burris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12 year 1943 hour 10 minute 30 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 — Duration
Pneumonia
Due to
Due to Sever Exposure and Lack of Care
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 Joe E. Wheeler Coroner (M. D. or other)
Address Bethany Mo Date signed 1-14-43

.50

(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.....

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

working under my personal supervision.

Signed.....Joe E Wheeler

Licensed Embalmer No.....3512

P. O. Address.....Bethany Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit 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
I X29289

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. 2330

Registration District No. 133 Primary Registration District No. 5483 Registrar's No. 4

1. PLACE OF DEATH:
(a) County: Harrison
(b) City or town: Bethany (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: William C. Brown
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: Feb (Month) 7 (Day) 1865 (Year)
8. AGE: Years 78 Months 6 Days If less than one day min.
9. Birthplace (City, town, or county) Iowa (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
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 Jan Day 2 year 1943 hour minute 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.

	Duration
Immediate cause of death: Pneumonia	
Due to: Bronchial pneumonia	
Due to: Severe exposure and lack of care.	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature: Joe E. Wheeler (M.D. or other)
Address: Bethany Mo. Date signed

SUPPLEMENTARY