

FILED FEB 17 1942

Registration District No. 2

Primary Registration District No. 6263

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Webster

(b) City or town Smiths River Rural Town  
(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 \_\_\_\_\_ years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Massachusetts (b) County Webster 119

(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")

(d) Street No. 4 Miles West of Seymour Mo  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Oliver C. Bralley

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18  
year 1942 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 21  
1942 to 12-18 1942  
that I last saw him alive on 12-17 1942  
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or Race W.

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

6. (b) Name of husband or wife Mary E. Bralley

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

7. Birth date of deceased Sept 17 1892  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Pneumonia  
Resection of spine  
Due to fractured hip ✓

Due to Fall

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day

90 3 1 hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired farmer

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

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name Johnathan Bralley

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

14. Maiden name Margaret Bogle

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 119 ✓

(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 E. G. Beers (M. D. or other) ✓  
Address Seymour, Mo. Date signed 12-20-42

16. (a) Informant Lillian Patton

(b) Address Nelagoney Okla.

17. (a) Masonic Ceme (Burial, or cremation) (b) Date thereof Dec 23 1942  
(Month) (Day) (Year)

(c) Place: burial or cremation Masonic Ceme

18. (a) Signature of funeral director Kelley - Jernell

(b) Address Seymour Mo

19. (a) Dec 17 1942 (Date received local registrar) (b) Robert Jone (Registrar's signature)

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

RECEIVED

District Health Officer No. 6

District File Number

229-187

Date Filed FEB 12 1943

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

*H. H. Keller*

Licensed Embalmer No

3334

P. O. Address

*Reynolds*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7997

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Webster  
(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  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Oliver C. Brolley  
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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept - 17 - 1905  
(Month) (Day) (Year)

8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Webster  
(c) City or town Rural  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18  
year 1949 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Fractured hip  
pneumonia  
Due to \_\_\_\_\_  
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, ~~crime~~ fall

(b) Date of occurrence 11-20-1949

(c) Where did injury occur front porch (City or town) (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place?  
Home after dark walking

(e) Means of injury \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of work)

23. Signature E. G. Sellers (M. D. or other)

Address \_\_\_\_\_ Date signed 3-29-50

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

SUPPLEMENTARY

Kennel no Book (H...)

