

V. S. No. 2
 SOM-94-41
 Re. 5-17-99
 5-1 X 2-2-2

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **13503**

DECEASED **MAY 11 1943**

Registration District No. **1** Primary Registration District No. **1005** Registrar's No. **120**

1. PLACE OF DEATH:
 (a) County **Adair**
 (b) City or town **Rural City's Junc**
 (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 **2** (Specify whether
 In this community **54** years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Adair**
 (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? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Clarence Bragg**
 (b) If veteran, name war _____ (c) Social Security No. **2**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **29**
 year **1943** hour **6** minute **0** A. M.

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **single**
 (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: **June 22 1888**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr 7, 1943** to **Apr 29, 1943**
 that I first saw him alive on **Apr 28, 1943**
 and that death occurred on the date and hour stated above.

8. AGE: Years **54** Months **10** Days **7** If less than one day hr. _____ min. _____

Immediate cause of death: **Coronary Sclerosis with Occlusion**
 Due to **Diabetes**
 Due to **Hyperparathyroidism**
 Other conditions (Include pregnancy within 7 months of death) **Kyphosis**

9. Birthplace: **Adair Mo**
 (City, town, or county) (State or foreign country)

10. Usual occupation: **Farmer**

Major findings: **Diabetes**
 Of operations _____
 Of autopsy _____

MOTHER FATHER
 11. Industry or business _____
 12. Name: **Ezra Bragg**
 13. Birthplace: **Adair Mo** (City, town, or county) (State or foreign country)
 14. Maiden name: **Josephine**
 15. Birthplace: **Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant: **Dr. H. C. ...**
 (b) Address: **La Plata Mo**

17. (a) **Rural** (b) Date thereof: **May 1, 1943**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **La Plata Mo**

18. (a) Signature of funeral director: **Christie**
 (b) Address: **La Plata Mo**

19. (a) **5/4/43** (b) **Mrs. L. Waynes**
 (Date received local registrar) (Registrar's signature)

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) Years of injury _____
 23. Signature: **H. O. Newton** (M. D. or other)
 Address: **La Plata Mo** Date signed: **5/30/43**

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

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

60

RECEIVED

District Health Officer No. 10

District File Number 5-43-831

Date Filed MAY 10 1949

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 D.S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata 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.