

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 185

Primary Registration District No. 1003

FILED AUG 11 1943

Registration District No.

1. PLACE OF DEATH:

(a) County Adair Co.
(b) City or town Rural Monroe Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life _____ (Specify whether _____)
years, months or days

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 William Edward O BRIAN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10 14 1879
(Month) (Day) (Year)

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

69 8 25 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER } 12. Name W. O Brian
13. Birthplace Columbus Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Jane Jade
15. Birthplace Adair Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Charles Johnson
(b) Address State mo

17. (a) Funeral (b) Date thereof 7 11 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Shipley's First Bur

18. (a) Signature of funeral director Wm E Bent
(b) Address Green City Mo

19. (a) 7/13/43 (b) Mrs J. Waynes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1943 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from Nov 1942 to July 9 1943
that I last saw him alive on July 9 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease
Due to _____

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations No
Of autopsy No

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 H. A. Garrison (M. D. or other) M.D.
Address Springer Mo Date signed 7-10-43

Duration 5 years
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

1 Jan

X29484

1049

RECEIVED

District Health Officer No. 10

District File Number 8-43-1267

Date Filed AUG 10 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.