

10-2
5-42

FILED SEP 16 1943

Registration District No. **11**

Primary Registration District No. **4024**

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Cassville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barry County Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **one year & three months**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County **5**
(c) City or town _____ (If outside city or town limits, write "RURAL") **1**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **1**

3. (a) PRINT FULL NAME

J. P. Brough

3. (b) If veteran

name war **World War**

3. (c) Social Security

No. _____

4. Sex **male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Jacqueline**
M. Brough

(c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Oct. 24 1892**
(Month) (Day) (Year)

8. AGE: Years **50** Months **8** Days **29**

If less than one day _____ hr. _____ min.

9. Birthplace **Kiowa Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business

MOTHER FATHER { 12. Name **J. P. Brough**
13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Mollie Robinson**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ms. Jacqueline Brough**

(b) Address **Cassville, Mo.**

17. (a) **None** (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation **Oklahoma City, Okla.**

18. (a) Signature of funeral director **W. N. Kohn**

(b) Address **Cassville Mo.**

19. (a) **July 24-1943** (b) **Grace Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **23rd**
year **1943** hour **12:05** minute **a.** M.

21. I hereby certify that I attended the deceased from **July**
1943 to **July 23 1943**

that I last saw him alive on **July 23 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **uremia**

Due to **Cirrhosis of liver** **Unk.**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____ **124 fl**
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 _____

23. Signature **Deo. Newman** (M. D. or other)

Address **Cassville, Mo.** Date signed **7-24-43**

Disposition **54**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SEP 27 1943

RECEIVED
District Health Officer No. 6,
District File Number 943-1064
Date Filed 9-14-43

JAN 17 1950

MAR 2 1945
1945 & 1946

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.....

W. A. Feason

Registered Apprentice No.

working under my personal supervision.

Signed W. A. Feason

Licensed Embalmer No. 2456

P. O. Address Cassville, 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.

Registration District No. 11

Primary Registration District No. 7024

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Cassville
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME J. P. Brough

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 Oct 24 1898
(Month) (Day) (Year)

8. AGE: Years 50 Months 8 Days _____ If less than one day _____ min.

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

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 _____
(Burial, cremation, or removal) (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 Missouri (b) County Barry

(c) City or town Cassville
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MOTHER FATHER

31092