

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

31540  
Do not use this space.

OCT 7 1943

1. PLACE OF DEATH *Went*

(a) County *Went* Registration District No. *100*

(b) Township *Short Bend* Primary Registration District No. *5388*

(c) City *Stgo* (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Sarah Frances Bronch*

(a) Residence, No. *Stgo mo* St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *David Bronch*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 14 - 1856*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.

*87 1 27*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *MO*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 11 1943*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 1 1930 to Sept 11 1943*

Last saw her alive on *Aug 10 1943* Death is said to have occurred on the date stated above, at *7:30 a.m.*

The principal cause of death and related causes of importance were as follows:

*Chronic valvular disease of heart*

Other contributory causes of importance: *9/2/43*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) *R. B. Parker*, M. D.

(Address) *St. Louis Mo*

13. NAME *Wm. DeKroon*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *not known*

15. MAIDEN NAME *Dont Wroes*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *1*

17. INFORMANT (ADDRESS) *Edw. J. Patton Stgo Mo*

18. BURIAL, CREMATION, OR REMOVAL

\* PLACE *St. go, mo* DATE *9/12/43*

\*9. FUNERAL DIRECTOR *John Grantham Salem Mo*

20. FILED *9-11-43* 19\_\_\_\_ Local Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. S. NO. 2.  
50M-7-20-37

1 X12004

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 5,

1043590.....

10-6-43.

✓ STATEMENT BY LICENSED EMBALMER

I, ....., Licensed Embalmer No.....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E. ....  
No..... or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**