

FILED MAY 9 1944
Registration District No.

Primary Registration District No. 3008

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town London
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution aug-20 1919
(Specify whether)

In this community 17
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Andrew

(c) City or town Union 14
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? 2
(Yes or No)

If yes, name country 17

3. (a) PRINT FULL NAME Charlotte Branga

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

4. Sex Female 5. Color W 6. (a) Single, widowed, married, divorced, married
race W

6. (b) Name of husband or wife Charles Branga 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased not known
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name 571

13. Birthplace 575 9
(City, town, or county) (State or foreign country)

14. Maiden name 576

15. Birthplace 576 9
(City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address

17. (a) Removal (b) Date thereof 4-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Madison

18. (a) Signature of funeral director H. G. Branger

(b) Address Madison

19. (a) 4-21-44 (b) Josie M. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1944 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 11-20-1943 to 4-21-1944

that I last saw him alive on 4-20-1944 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
chronic myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 93d

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, 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 T. E. Sherrill (M. D. or other)

Address Grand Date signed 4/27/44

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

4
1
2

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 5-8-44

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. G. Grainger

Licensed Embalmer No.

81297

P. O. Address

Laddonia, Me

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.