. S. No. 2
00M—5-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18209

Registration District No. 84944 Primary Registration District No. 3026 Registrar's No. 120

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Indep. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Indep. Sanitarium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 2 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence (If outside city or town limits, write "RURAL")
(d) Street No. 311 East Elm (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME Sharon Kay Brooks

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

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased April (Month) 29 (Day) 1944 (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	2	hr. min.

9. Birthplace Independence (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Child
11. Industry or business —

FATHER
12. Name Joseph Brooks
13. Birthplace Indep. (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Enid Fosberg
15. Birthplace Bayard (City, town, or county) Neb (State or foreign country)

16. (a) Informant Joseph Brooks
(b) Address 311 East Elm
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mound Grove
18. (a) Signature of funeral director Geo C. Carson
(b) Address Indep. Mo.
19. (a) 5/2/44 (Date received local registrar) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 1 year 1944 hour 1 minute 50 P.M.

21. I hereby certify that I attended the deceased from 4-29-44, 19__, to 5-1, 1944; that I last saw her alive on 5-1-, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (wt. 2 # 11 1/4 oz. 6 1/2 mos gestation)
Due to X ray of chest negative
Due to
Other conditions None (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy None done

Duration

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

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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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Russell Fuhrmann MD (M. D. or other) MD
Address Independence Date signed May 2, 1944

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(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.