o. 2
-4-41
7-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1944

Registration District No. 187

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18547

Primary Registration District No. 3040

Registrar's No. 21

1. PLACE OF DEATH:

(a) County LIVINGSTON

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

(c) Name of hospital or institution: CHILLICOTHE HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 DAYS (Specify whether

In this community years, months or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALDWELL 13

(c) City or town BRECKENRIDGE (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 MATT SELMON BRURCKHARTT

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 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased JULY (Month) 15 (Day) 1869 (Year)

8. AGE: Years 74 Months 10 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business DRUGIST

FATHER
12. Name MATT N. BURCKHARTT
13. Birthplace HOWARD Co (City, town, or county) MOO (State or foreign country)

MOTHER
14. Maiden name JULIAN JACKSON
15. Birthplace (City, town, or county) KY (State or foreign country)

16. (a) Informant B. J. BURCKHARTT

(b) Address Breckenridge MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof May 20 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director T. McPeek

(b) Address Breckenridge MO.

19. (a) June 4 (Date received local registrar) (b) Lou Elha Curry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1944 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from May 15, 1944, to May 18, 1944 that I last saw him alive on May 18, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Surgical shock	11 hrs
Due to Bowel resection	–
Due to Ring Cancer of Sterm & Bowel obstruction	?
Other conditions (Include pregnancy within 3 months of death) Bronchial pneumonia	4 days

Major findings: Of operations Ring Cancer of Sterm.

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. J. Brennan (M. D. or other)

Address Chillicothe, Mo Date signed 5-20-44

458

(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 T. F. McPeek, Registered Apprentice No. ..... working under my personal supervision.

Signed T. F. McPeek

Licensed Embalmer No. 1570

P. O. Address Breckenridge

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
--5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 71

1. PLACE OF DEATH:
(a) County: Livingston
(b) City or town: Chillicothe (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chillicothe Hospital (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

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: CALDWELL
(c) City or town: BRECKENRIDGE (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: Matthew N. Brandhorst
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, divorced: SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: July 6 (Month) (Day) 1866 (Year)
8. AGE: Years 94 Months 10 Days 4 If less than one day: hr. min.
9. Birthplace: (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 20 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Rose Hill Cemetery
18. (a) Signature of funeral director: [illegible]
(b) Address: Breckenridge Mo
19. (a) June 4 (Date received local registrar) (b) Lou E. Lafferty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 9 year: 1944 hour: minute: M.
21. I hereby certify that I attended the deceased from, 19, to, 19; that I last saw him alive on, 19; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

FILED

18547