DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 10 1944

Registration District No. _____

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21246

Primary Registration District No. 5183

Registrar's No. 26

1. PLACE OF DEATH:
(a) County: CAPE GIRARDEAU
(b) City or town: RURAL BYRD TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3 Miles South west of Jackson
(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: 71 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cape Girardeau
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 3 Miles South-West Jackson
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: DANIEL-FRANK-BRENECKE
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: EMMA-SOELIG
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: MAY (Month) 8 (Day) 1873 (Year)

8. AGE: Years	Months	Days	If less than one day
71	1	17	hr. min.

9. Birthplace: CAPE-GIRARDEAU (City, town, or county) MO (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business _____
FATHER
12. Name: FRANK-BRENECKE
13. Birthplace: CAPE-GIRARDEAU (City, town, or county) MO (State or foreign country)
MOTHER
14. Maiden name: ANNA-KUEHLE
15. Birthplace: CAPE-GIRARDEAU (City, town, or county) MO (State or foreign country)
16. (a) Informant: Emil Brenecke
(b) Address: Cape Girardeau MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-27-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Wilson-Stather-Seabaugh
(b) Address: Jackson MO
19. (a) 6/26 (Date received by local registrar) (b) J. H. Kuehne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1944 hour 11 minute 15 a.m.
21. I hereby certify that I attended the deceased from Mar _____, 1944, to June 25, 1944 that I last saw him alive on Mar 17, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	5 min
Due to: Coronary disease	6 mos
Due to: ?	
Other conditions (Include pregnancy within 3 months of death): Not Pr Nip	3 mos

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature: T. E. Ruff (M. D. or other) MD
Address: Jackson Mo Date signed 6-26-44

1116

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 244-4084

Date Filed 2-8-44

APR 9 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 .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.

2B
43
36930

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. July

Registration District No. 52 Primary Registration District No. 5183 Registrar's No. 26

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Rural Byrd Twp.
(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
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Daniel F. Brenecke

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 May (Month) 8 (Day) 1873 (Year)

8. AGE: Years 71 Months 1 Days 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, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	5 min
Due to coronary disease	6 mos.
Due to	
Other conditions Fracture of hip (Include pregnancy within 3 months of death)	3 mos

Major findings:
Of operations 186a
Of autopsy 39

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) accident

(b) Date of occurrence Mar 21 1944

(c) Where did injury occur? (Rural) (City or town) Cape Girardeau (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On farm - near his dwelling (Specify type of place)
While at work? yes (e) Means of injury Fall

23. Signature T. E. Ruff (M. D. or other) MD
Address Jackson Mo Date signed 7-23-44

21246