

FILED JUL 6 1944
Registration District No. 683

Primary Registration District No. 5312

1. PLACE OF DEATH:

(a) County Cooper Co
(b) City or town Phenix - Clarks Ford
(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 Life - years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County COOPER
(c) City or town Phenix 27
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? no
If yes, name country _____

3. (a) PRINT FULL NAME Theodore L. Brandes

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 ✓
6. (b) Name of husband or wife Luzie Brandes 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug - 2nd 1879 (Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Charley Brandes

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

14. Maiden name Wagner Lee Schmidt

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

16. (a) Informant Arthur Brandes

(b) Address Burtonton Mo

17. (a) Burial (b) Date thereof 6-28 44 (Month) (Day) (Year)

(c) Place: burial or cremation Long Elm mo

18. (a) Signature of funeral director Thumelino
(b) Address _____
19. (a) June 30 - 1944 (Date received local registrar) (b) Mrs. N. L. Keays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1944 hour 9 minute 30 AM

21. I hereby certify that I attended the deceased from June 26 1944 to June 26 1944

that I last saw him alive on 6-26 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cornmeal through bowels Duration 24 hrs

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 94 a

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature A. L. Meredith (M. D. or other) Phenix

Address Phenix House Date signed 6-27-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1137

no

RECEIVED

District Health Officer No. 8,

District File Number

Filed 7-5-47

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.....

my self

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

working under my personal supervision.

Signed.....

L Y Parker

Licensed Embalmer No.....

25 47

P. O. Address.....

Burdett 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. _____

Registration District No. 83 Primary Registration District No. 5312

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Rural Clark Imp.
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Theodore S. Brander
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 Married
6. (b) Name of husband or wife type 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 2 1879
(Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

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

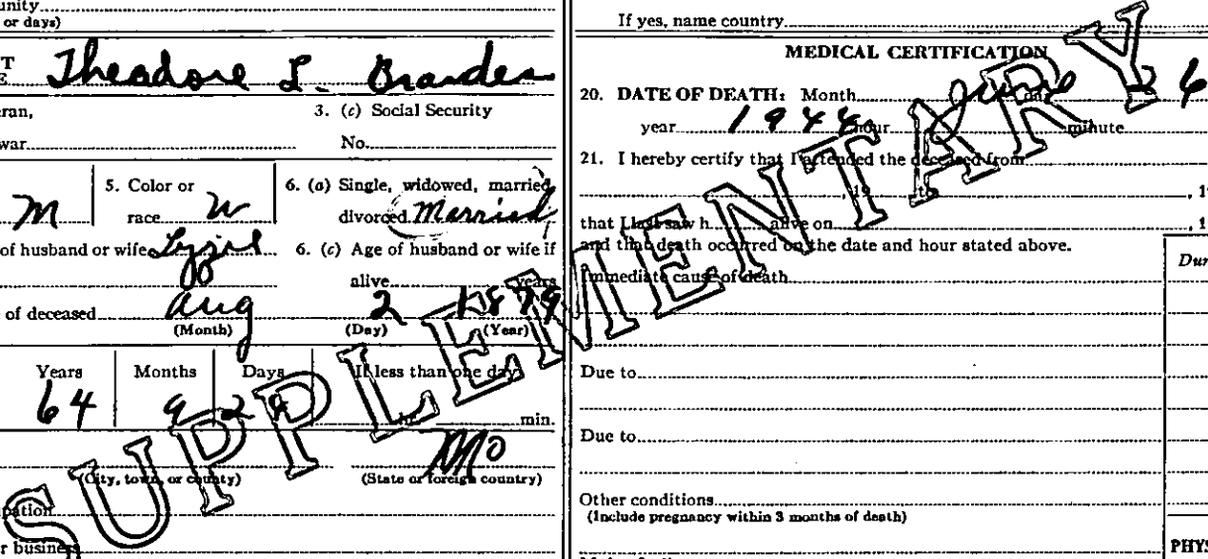
2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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



21426