

S. No. 2  
DM-8-43  
v. 5-17-39  
P1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31243

State File No. \_\_\_\_\_

FILED OCT 13 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 3035

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Lexington  
(c) Name of hospital or institution D. 17th St.  
(d) Length of stay: In hospital or institution 1  
In this community 27 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette  
(c) City or town Lexington 54  
(d) Street No. D. 17th St. 3  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARYELLEN BROOKS

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife U.C. Brooks 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 24 1918  
(Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 0 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Jacob Young  
13. Birthplace Cumberland Co. Tenn.  
14. Maiden name Sarah Ann Young  
15. Birthplace Sherman Co. MO  
(City, town, or county) (State or foreign country)

16. (a) Informant G.A. Brooks  
(b) Address Lexington, MO  
17. (a) Burial, cremation, or removal Business (b) Date thereof 9-26-44  
(Month) (Day) (Year)  
(c) Place: burial or cremation Lexington, MO

18. (a) Signature of funeral director Ernest F. Kempf  
(b) Address Lexington, MO  
19. (a) Sept. 25, 1944 (b) Mrs. Fred Schwab  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24 year 1944 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 9-1944 to Sept. 24, 1944 that I last saw her alive on Sept. 23, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure  
Duration about two hrs  
Due to acute dilatation from high blood pressure  
Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations 9504  
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 G.O. Cope (M. D. or other) 9/25/44  
Address Lexington, MO Date signed \_\_\_\_\_

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

RECEIVED  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed \_\_\_\_\_

10-11-41

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 J. E. McKeary

Licensed Embalmer No. 2983

P. O. Address Stoughton, 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.