

FILED DEC 8 1944

Registration District No. 1

Primary Registration District No. 4265

Registrar's No. 50

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

400

I. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Napoleon
(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 _____
In this community Born Here 1887 (Specify whether years, months or days)

8. (a) PRINT FULL NAME GUSTAV BRACKSICK

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Oct. 9 - 1887
(Month) (Day) (Year)

8. AGE: Years 57 Months 2 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Lafayette County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Retired

MOTHER FATHER { 12. Name Fred Bracksick 13. Birthplace Germany 14. Maiden name Helena Beckmayer 15. Birthplace Germany

16. (a) Informant Eduard Beckmayer (b) Address Napoleon Mo

17. (a) Burial (b) Date thereof 11-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Napoleon Mo

18. (a) Signature of funeral director Green Funeral Home

(b) Address Wellington Mo

19. (a) Nov-27-1944 (b) Miss W.F. Baker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette 54
(c) City or town Napoleon Mo 13
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17
year 1944 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from Jan. 25th 1944 to Nov. 17th 1944
that I last saw him alive on Nov 9th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____
Due to 120

Other conditions (Include pregnancy within 3 months of death)

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) (e) Means of injury _____

23. Signature R.B. Watts (M. D. or other) _____
Address Wellington Date signed 11-11-44

Duration 3 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,

District File Number _____
Filed 12-7-74

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 _____

W. Roy Ewen

Licensed Embalmer No. 4305

P. O. Address Wellington, 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, above space should be left blank.