

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40924

State File No. _____
Registrar's No. 167

Registration District No. 71
Primary Registration District No. 3012

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Excelsior Springs, Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. U
(Specify whether
In this community _____
years, months or days)

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

3. (a) PRINT FULL NAME Clara A. Brosnihan
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced. Widowed
6. (b) Name of husband or wife Jerry Brosnihan
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 4th 1852
(Month) (Day) (Year)

8. AGE: Years 92 Months 5 Days 2
If less than one day hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name T. D. Clarkson

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

14. Maiden name Hannah Ferguson

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

16. (a) Informant Mrs. Mary C. Kautz

(b) Address Kansas City, Missouri

17. (a) Removal (b) Date thereof 12-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Mo

19. (a) 12-7-44 (b) Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
year 1944 hour 11 minute A.M.

21. I hereby certify that I attended the deceased from Nov. 23-1944
to Dec 6, 1944
that I last saw her alive on Dec 6, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia
Due to Fracture of 7th rib - rib side
Due to Senility

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. M. Louch (M. D. or other) M.D.
Address Excelsior Springs, Mo Date signed 12/7/44

Duration 6 mos
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-9-78

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

Carl Rapp

Licensed Embalmer No.

3458

P. O. Address

Co. Spgs 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.

State File No. _____
Registrar's No. 167

Registration District No. 71 Primary Registration District No. 3012

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

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs
 (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 Clara A. Brosnihan
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4, 1905
 (Month) (Day) (Year)

8. AGE: Years 92 Months 6 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 1944 year 19 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 1944 _____ 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) Accident
 (b) Date of occurrence Nov. 23 - 1944
 (c) Where did injury occur? Excelsior Spg Clay Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
At home
 While at work? (Specify type of place) _____
 (e) Means of injury

23. Signature Russelouch M.D. (M. D. or other) _____
 Address Excelsior Springs Mo Date signed 1/15/45

SUPPLEMENTARY

40924