

FILED JAN 25 1945

Registration District No. 66-4346

Primary Registration District No. 34-4507

1. PLACE OF DEATH

(a) County Stone
 (b) City or town Crane, Mo
 (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 about 5.5 yrs years, months or days

3. (a) PRINT FULL NAME Ruth Alma Bree

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

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Sept 6. (c) Age of husband or wife if alive 3 years
 7. Birth date of deceased (Month) (Day) (Year) 1860

8. AGE: Years 82 Months 9 Days 12 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name William Brouse

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

14. Maiden name Cynthia

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

16. (a) Informant Mrs Homer Campbell

(b) Address Crane Mo

17. (a) Burial (b) Date thereof June 16-43 (Month) (Day) (Year)

(c) Place: burial or cremation Helena

18. (a) Signature of funeral director Emeritt J. Cheatham

(b) Address Helena Mo

19. (a) 6/6/43 (b) Henry Manton (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone 104
 (c) City or town Crane 1
 (If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15 day June
 year 1943 hour 8 minute 9 M.

21. I hereby certify that I attended the deceased from after death to 1943
 that I last saw her alive on June 1 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
 Due to arteriosclerosis 10 yr.
 Due to senility

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

Major findings: Of operations 430
 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 H. L. Terr (M. D. or other)
 Address Crane Mo Date signed 6-16-43

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

RECEIVED
District Health Officer No. 6;
District File Number 145-97
Date Filed JAN 17 1945

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 Everett J. Cheatham
Licensed Embalmer No. 3870
P. O. Address Galena, 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.