

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

FILED MAR 15 1946

Registration District No. 117

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5436

State File No.

6082

Registrar's No.

1. PLACE OF DEATH:

(a) County Gasconade
 (b) City or town Lapeer Mo. - R. 10
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Rural - Boulevard
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME HADE BRANSON

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 Viola M. OWENS 6. (c) Age of husband or wife if alive 58 years
 7. Birth date of deceased Jan 8 - 1884
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 1 9 hr. min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Tom Branson
 13. Birthplace Osage Co. Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Branson
 15. Birthplace Osage Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hade Branson
 (b) Address Lapeer - Mo. R. 10.

17. (a) Burial (b) Date thereof 2-22-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Clyde Norton
 (b) Address Lapeer Mo.

19. (a) 2-21-45 (b) Mrs. F. B. Meyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Gasconade
 (c) City or town Lapeer - Rural
 (If outside city or town limits, write "RURAL")
 (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 2 day 17
 year 1945 hour 8 minute 30 AM.

21. I hereby certify that I attended the deceased from 1/24/1944
 to 2/11/1945
 that I last saw him alive on 2/11/1945
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Circulatory Failure
Myocardial Infarction
Coronary Infarction
(Repeated)
Many
years
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
 Of operations _____
 Of autopsy 930
 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 2
 23. Signature: B. B. von Esch (M. D. or other) MD
 Address Cherokee, Mo. Date signed 2/19/45

(Licensed Embalmer's Statement on Reverse Side)

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

1262

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 3-13-45

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 _____,

Ormer H. Jones, Registered Apprentice No. 373,
working under my personal supervision.

Signed _____

Licensed Embalmer No. 3701

P. O. Address Jefferson City, 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.