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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 4 1945

Registration District No. 1

Primary Registration District No. 5465-A 5468

Registrar's No. 70

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Strafford, Rural R#1 Taylor, Twp
(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) 1

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Strafford, Rural, Taylor, Twp.
(If outside city or town limits, write "RURAL")

(d) Street No. 39
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Adolphus Wilburn Brake

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased May (Month) 4 (Day) 1861 (Year)

8. AGE: Years 83 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Greene Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Retired Farmer.

11. Industry or business

FATHER
12. Name Steve Brake
13. Birthplace (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name Jane Riley
15. Birthplace (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant Mrs. Emma Foley
(b) Address Strafford, Mo, R#1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Shiloh Cemetery

18. (a) Signature of funeral director Kelley-Ferrell
(b) Address Robersville, Mo.

19. (a) 3/9/45 (Date received local registrar) (b) Garland Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 4, 1945
year 4 hour 30 minute P. M.

21. I hereby certify that I attended the deceased from Feb 1, 1945 to March 4, 1945
that I last saw him alive on March 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	4 days
Due to Ilio-Femoral vein Thrombosis	14 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

107

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature R. H. Focht (M. D. or other) MD
Address Strafford Mo Date signed 3/9/45

1246

(Licensed Embalmer's Statement on Reverse Side)

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 H. H. Kelley

Licensed Embalmer No. 3334

P. O. Address Seymour, 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.