

S. No. 2
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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19989

FILED JUL 14 1945

Registration District No. 47

Primary Registration District No. 3005

Registrar's No. 205

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(c) Name of hospital or institution State Hosp #1 2
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 5-6-35
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Anson
(c) City or town Prairie Home
(If outside city or town limits, write "RURAL") 14
(d) Street No. 14
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Emma Broader

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife H. P. Broader

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased

January 20 1981
(Month) (Day) (Year)

8. AGE:

Years 64 Months 5 Days 9
If less than one day
hr. min.

9. Birthplace

MD
(City, town, or county) (State or foreign country)

10. Usual occupation

DTC

11. Industry or business

12. Name

William Kiel

13. Birthplace

MD
(City, town, or county) (State or foreign country)

14. Maiden name

Louise Hornbeck

15. Birthplace

MD
(City, town, or county) (State or foreign country)

16. (a) Informant

Record

(b) Address

17. (a) Prairie Home Md

(b) Date thereof June 29 1945
(Month) (Day) (Year)

(c) Place: burial or cremation

Prairie Home R. F. D.

18. (a) Signature of funeral director

C. Albert Hornbeck

(b) Address

Prairie Home Md

19. (a) 6-29-45

(b) Joac M...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 29
year 1945 hour 11 minute 40 M.

21. I hereby certify that I attended the deceased from 11 26 19 42 to 6-29-45 19 45
that I last saw her alive on 6-29- and that death occurred on the date and hour stated above.

Immediate cause of death Epilepsy!
Duration

Due to
Due to

Other conditions Epilepsy
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none performed

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?

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

23. Signature J. E. Sherrill (M. D. Doctor)
Address Fulton Md Date signed 6/29/45

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

1071.2
24-5-11.2
<10

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-13-45

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Praine Home

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.

43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 2015

Registration District No. 47 Primary Registration District No. 2008

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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

3. (a) PRINT FULL NAME Emma Breede

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

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Jan 20
(Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 7
Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Broncho Pneumonia
Gilespay

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature K.E. Starnes (M. D. or other) _____
Address Fulton Date signed 6/30/48

SUPPLEMENTARY

S-19989