

FILED JUN 28 1945 **41**

Primary Registration District No. **3025**

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

1. PLACE OF DEATH:
 (a) County Waukegan
 (b) City or town West Plains
(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 years, months or days) 6 yrs.

3. (a) PRINT FULL NAME Jacob Iley Braden
3. (b) If veteran, **3. (c) Social Security name war** **No.** _____

4. Sex male **5. Color or race** W **6. (a) Single, widowed, married, divorced** W
6. (b) Name of husband or wife Olga M. Braden **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased 7-6-1864
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer & Railroader

11. Industry or business _____

12. Name Joseph F. Braden

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

14. Maiden name _____

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

16. (a) Informant Melvin E. Braden

(b) Address W. Plains, Mo.

17. (a) _____ **(b) Date thereof** 5/7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. Plains

18. (a) Signature of funeral director Robert Johnson

(b) Address West Plains, Mo.

19. (a) 7-20-45 **(b)** Paul H. Taylor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Waukegan
 (c) City or town West Plains
(If outside city or town limits, write "RURAL")
 (d) Street No. Mo. Ave.
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 5 year 1945 hour 10 minute 00 AM

21. I hereby certify that I attended the deceased from 3-11-1945 to 5-5-1945

that I last saw him alive on 4-3-1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis

Due to _____

Due to 138'

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) (Means of injury)

23. Signature Robert Johnson (M. D. or other) MD
 Address West Plains, Mo. Date signed 5-8-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 363

District File Number 645-~~874~~

Date filed 6.27.45-

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 P. D. Roberts

Licensed Embalmer No. 3437

P. O. Address West Haven, Ct.

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.