S. No. 2
DM—2-43
V. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Kelly

27356 ✓

State File No. 27356

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 646

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1303 Cairo
(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)
In this community: 19 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Springfield
(If outside city or town limits, write "RURAL")

(d) Street No.: 1303 Cairo
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Ulysses S. Brey

3. (b) If veteran, name war: No

3. (c) Social Security No.: UNK.

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Maggie K. Brey

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

7. Birth date of deceased: Oct. (Month) 5 (Day) 1865 (Year)

8. AGE: Years 79 Months 10 Days 12 If less than one day ____ hr. ____ min.

9. Birthplace: Okolona (City, town, or county) Ohio (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: R.R. Telegrapher

MOTHER FATHER

12. Name: Gideon Brey

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

14. Maiden name: Unknown

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

16. (a) Informant: Mrs. Maggie Brey

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Hazelwood

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 8-18-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 17 year: 1945 hour: 5 minute: 15 a. M.

21. I hereby certify that I attended the deceased from 1-2-, 1940 to 8-17-, 1945 that I last saw him alive on 8-16-, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerosis

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Major findings: Of operations: 97

Of autopsy: ____

Duration

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: [illegible] (M. D. or other)

Address: Springfield, Mo. Date signed: 8-19-45

984 (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 L Doolin Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield 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.