S. No. 2
I—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27795

Registration District No. 179 Primary Registration District No. 2667 Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Bedford Twp. Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Farm 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yr 4 mo 19 Days (Specify whether)

In this community 2 years 4 mo 19 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln 57

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Carl Briete

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 unknown

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day

unknown hr. min.

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

10. Usual occupation unknown

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Roy Cox

(b) Address Troy, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Co. Farm

18. (a) Signature of funeral director Kemper Funeral Home

(b) Address Troy, Mo

19. (a) Aug 18, 1945 (Date received local registrar) (b) Pauline McGregor (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 29 year 1945 hour 12 minute noon M.

21. I hereby certify that I attended the deceased from June 1, 1945 to July 29, 1945 that I last saw him alive on July 29, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

162 K

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 J. C. Cosrech (M. D. or other)

Address Troy, Mo Date signed Aug 7/45

1386

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 9-6-45

not embalmed

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.....

Licensed Embalmer No.....

P. O. Address.....

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.