

FILED JAN 11 1946

Registration District No. 100

Primary Registration District No. 5389

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Rural SinkingTwp
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near Bunker, Mo
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Albert Brookes

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

4. Sex M 0 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Brookes 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Aug 4 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 3 28
hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name No record

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Sarah Brookes

(b) Address Bunker, Missouri

17. (a) Burial (b) Date thereof 12/4/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bunker Cemetery

18. (a) Signature of funeral director L. L. Stenson

(b) Address Salem, Missouri

19. (a) 12-4-45 (b) M. M. Neal, M.D. by death
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2
year 1945 hour 2:00 P.M. 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 of age infermeries
Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 L. L. Stenson (M. D. or other) _____

Address Bunker, Mo Date signed 12-3-45

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

MOTHER FATHER

1423

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5.

District File Number 14683

Date Filed 1-9-46

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 *Wm. W. McDonald*

Licensed Embalmer No. 3806

P. O. Address *Salem, 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.