

FILED JAN 9 1947
Registration District No. 1

Primary Registration District No. 5429

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Beaufort Lyon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life time
years, months or days

3. (a) PRINT FULL NAME Mary Brockman
3. (b) If veteran, name war _____
3. (c) Social Security No. None

4. Sex F
5. Color or race w.
6. (a) Single, widowed, married, divorced w.
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 20 1866
(Month) (Day) (Year)
8. AGE: Years 80 Months 6 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Karmier
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Charlotte Lefmann
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Fred H Brockman
(b) Address Germany Mo.

17. (a) Buried (b) Date thereof Jan 2 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau

18. (a) Signature of funeral director H. J. Matthews

(b) Address Beaufort Mo.
19. (a) 1-1-47 (b) H. J. Matthews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30
year 1946 hour 6 minute 2 A.M.
21. I hereby certify that I attended the deceased from Dec 29 1946
to Dec 29 1946
that I last saw alive on Dec 29 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Atherosclerosis
Due to _____
Due to _____

Other conditions AD
(Include pregnancy within 3 months of death)
Major findings: No operation
Of operations _____
Of autopsy No autopsy

22. If death was due to external causes, fill in the following:
(c) 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)
(a) While at work? _____ (c) Means of injury _____
23. Signature H. J. Matthews (M. D. or other) _____
Address Beaufort Mo. Date signed 12-31-46

Duration Known
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1-3-4
No. 32
JAN 11 1947
T. J. J. J.

RECEIVED
District Health Officer No. 9
District File Number
Date Filed JAN 8 1947

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.....

E. H. Lemme

Registered Apprentice No.....

working under my personal supervision.

Signed *E. H. Lemme*

Licensed Embalmer No. *3076*

P. O. Address *Beaufort 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.

Registration District No. 112

Primary Registration District No. 5429

1. PLACE OF DEATH:

County Franklin
City or town Bearport
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Mary Brockman

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

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

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

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

8. AGE: Years 80 Months 6 Days _____ If less than one day _____ hr. _____ min.

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

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-147 (b) J. Matthews
(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 _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

40158