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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 30 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

*D. Walker*  
State File No. 890  
Registrar's No. 19

Registration District No. 137

Primary Registration District No. 3023

1. PLACE OF DEATH:  
(a) County Henry  
(b) City or town Clinton Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
803 n 3rd St 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 16 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Henry <sup>42</sup>  
(c) City or town Clinton Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. North 3rd St 2  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gordon Hamilton Brough  
(b) If veteran, name war ✓  
(c) Social Security No. 490-05-9120

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 21  
year 1947 hour 5 minute A.M.

4. Sex: MD 5. Color or race W  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Cora H.  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: 12 13 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April, 1946, to 1-21, 1947,  
that I last saw him alive on 1-15, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bronchial Asthma & myocarditis  
Duration 1 yr.

8. AGE: Years 70 Months 1 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Electrical Employee

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 93E  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

22. If death was due to external causes, fill in the following:

MOTHER FATHER {  
12. Name Joly Brough  
13. Birthplace Adam Co. Penna  
(City, town, or county) (State or foreign country)  
14. Maiden name Julia Belesome  
15. Birthplace Ad. Kenner Co. Mo.  
(City, town, or county) (State or foreign country)

(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? \_\_\_\_\_

16. (a) Informant Cora S. Brough  
(b) Address: Clinton Mo.

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury 0

17. (a) Burial (b) Date thereof 1-23-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Laurel Park

23. Signature: D. Walker (M. D. or other) M.D.  
Address Clinton Mo Date signed: 1-22-47

18. (a) Signature of funeral director D. Walker  
(b) Address Clinton Mo  
19. (a) 1-22-47 (b) B. B. Kennedy  
(Date received local registrar) (Registrar's signature)

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

FEB 20 1947

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12-46-2003  
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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.....

*Fred W. Wilkerson*  
working under my personal supervision.

Registered Apprentice No. *4304*

Signed *Fred W. Wilkerson*

Licensed Embalmer No. *2478*

P. O. Address *Clinton, 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.