

No. 2
-8-43
5-17-39
1-337623

FILED JUN 27 1947
Registration District No. 7

Primary Registration District No. 3008

State File No. _____
Registrar's No. 224

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital no 12
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution up 9 mo 21 days
(Specify whether)

In this community see
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion

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

(d) Street No. 256 North Locust
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME INEZ R BROOKS

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife John P Brooks

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

7. Birth date of deceased Aug 16 1889
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name J B Laws

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

14. Maiden name Clara McElhenny

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

16. (a) Informant Records State Hosp Ft Mo

(b) Address Fulton Mo

17. (a) Burial (b) Date thereof June 16 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hannibal, Mo.

18. (a) Signature of funeral director Glenn G. Maupin

(b) Address 712 Cent Fulton, Mo.

19. (a) 6-15-1947 (b) Josie M. Moschetti
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1947 hour 11 minute 30 a M.

21. I hereby certify that I attended the deceased from July 17 47 to June 14 47

that I last saw her alive on June 14 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Paralysis

Due to Anesthesia during for Fractured right hip

Due to _____

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

Major findings: fracture right hip

Of operations _____

Of autopsy _____

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 J B Laws M.D. (Physician or other)

Address Fulton Mo 6/14/47

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

MOTHER FATHER

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 26 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
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Glen H. Manspin*
Licensed Embalmer No..... *2725*
P. O. Address..... *Fulton, 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.

July
June
22 y

43880

Registration District No. 47

Primary Registration District No. 3008

Registrar's No.

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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 _____ (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 _____

3. (a) PRINT FULL NAME

May R. Broche

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex I 5. Color of race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Aug 16 1914
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 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 _____

MOTHER FATHER { 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) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 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 _____

Due to _____
Due to _____ 1914

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) accident
(b) Date of occurrence May 28 - 1947
(c) Where did injury occur? Fulton Callaway MO
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Stab Hospital

While at work? _____ (Specify type of place) (e) Means of injury falling

23. Signature R. P. Price (M.D. or other) _____
Address Fulton MO Date signed 7/2/47

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

SUPPLEMENTARY

S-20237