

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21542**

Registration District No. **184**

Primary Registration District No. **3038**

Registrar's No. **46**

1. PLACE OF DEATH:
 (a) County Linn
 (b) City or town Brookfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: M. Barney Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Days
 In this community 48 Years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Linn
 (c) City or town Brookfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 721 N Main
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME: JACOB HENRY FUOSS
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 4
 year 1947 hour 3 minute 30 P.M.
 21. I hereby certify that I attended the deceased from 5-14
 _____, 1947, to 6/4, 1947,
 that I last saw him alive on 6/4, 1947,
 and that death occurred on the date and hour stated above.

4. Sex Mo 5. Color of R 6. (a) Single, widowed, married, divorced M
 (b) Name of husband or wife Tola B. Fuoss 6. (c) Age of husband or wife if alive 82 years
 7. Birth date of deceased Sept - 12 - 1863
 (Month) (Day) (Year)

Immediate cause of death Uremia
 Duration _____

8. AGE: Years 83 Months 8 Days 22 hr. _____ min. _____
 If less than one day

Due to Hypertensive cardiac vascular disease
 Due to Uremia, Generalized arteriosclerosis
 Other conditions _____
 (Include pregnancy within 3 months of death)

MOTHER FATHER

9. Birthplace Bed Moreland Co Pa
 (City, town, or county) (State or foreign country)
 10. Usual occupation Retired Jeweler
 11. Industry or business _____
 12. Name D.H.
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name D.H.
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)
 16. (a) Informant Mrs Tola B. Fuoss
 (b) Address Brookfield Mo
 17. (a) Burial (b) Date thereof June - 6 - 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Rose Hill
 18. (a) Signature of funeral director Bill Funeral Home
 (b) Address Brookfield Mo
 19. (a) 6-10-47 (b) Walter Bland
 (Date received local registrar) (Registrar's signature)

Major findings: 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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Ralph W. Roberts (M. D. or other) _____
 Address Brookfield Mo Date signed 6/8/47

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

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

DISTRICT HEALTH OFFICE
Cameroo, Mo.

JUL 1

1943

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

J. R. Blacklock

Licensed Embalmer No. *2746*

P. O. Address *Brookfield 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.