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1-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27164**

FILED AUG 25 1947

Registration District No. **82**

Primary Registration District No. **3017**

Registrar's No. **124**

1. PLACE OF DEATH:

(a) County **COOPEY**

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

(c) Name of hospital or institution: **PAVENSWAY HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 DAYS**
(Specify whether)

In this community **60 yr.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **MONITEAU**

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

(d) Street No. **NEAR UPPIUS MO**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **HENRY L. BRIZENDINE**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or **WHITE**

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

6. (b) Name of husband or wife **AGNES BRIZENDINE**

6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **12-4-1879**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
67	7	29	hr. _____ min. _____

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

10. Usual occupation **FRYING**

11. Industry or business _____

MOTHER FATHER

12. Name **JOEL BRIZENDINE**

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

14. Maiden name **NANCY EPPS**

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

16. (a) Informant **Frances E. Crawford**

(b) Address **5165 Morrow, Marshall, Mo**

17. (a) **REMOVABLE** (b) Date thereof **8-5-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. ZION CEM.**

18. (a) Signature of funeral director **C. Albert Hornbeck**

(b) Address **Praine Home, Mo**

19. (a) **8-5-47** (b) **De Hooper**
(Date received local registrar) (Registrar signature) **301**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **3**
year **1947** hour **10** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **7/13/47**
19 to **8/3/47** 19;
that I last saw him alive on **8/3/47** 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Encephalitis**

Due to _____

Due to _____

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

Major findings: **COB**

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)

(z) Means of injury _____

23. Signature **W. H. Ransaw** (M. D. or other) **8/5/47**
Address **Boonville Mo** Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 9

District File Number _____

Date Filed 8-29-47

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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.