

Registration District No. **364**

Primary Registration District No. **6237**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Warren**
(b) City or town **Stacy Grove**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **9**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Albert William Bratenick**

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 8 1898**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 4 4 hr. min.

9. Birthplace **Warren Co Mo U**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Henry Bratenick**

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

14. Maiden name **Martha**

15. Birthplace **St Charles Mo A**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edwin Bratenick**

(b) Address **Martha ville Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7/25/48**
(Month) (Day) (Year)

(c) Place: burial or cremation **Cypress Cemetery**

18. (a) Signature of funeral director **Wright City Mo**
(b) Address **Wright City Mo**

19. (a) **July 15 48** (b) **Mrs. F. W. Hughes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Warren**
(c) City or town **Rural**
(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 **Not known** year **1949** hour **Not known** minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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: **(Strangulation) (Causes of death) Due to hanging himself with wire from limb of tree**
Due to **suicide**

Duration

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

Major findings: **1640**
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) **Suicide**
(b) Date of occurrence **Not known**
(c) Where did injury occur? **Warren Mo** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **on farm** (Specify type of place)
While at work **No** (e) Means of injury **hanging**
23. Signature **W. E. H. Knepper** (X. D. or other)
Address **Warren** Date signed **July 14 1948**

MOTHER FATHER

APR 28 1948
Date Filed
JUL 23 1948
District File Number
District Health Officer No. 9,
RECEIVED

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.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

947
State File No. Sept
10

Registration District No. 364

Primary Registration District No. 6237

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Hickory Hill
(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

Albert W. Brakensiek

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

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

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

7. Birth date of deceased March 8 (Month) (Day) (Year)

8. AGE: Years 50 Months _____ 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) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1947 hour _____ 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 (Venous thrombosis) Duration _____

By hanging from limb of tree

Due to with disease

(suicide)

Due to P.S. fast sun blue

on Oct. 14 - 1947

Other conditions Found July 11 - 1948
(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) Suicide

(b) Date of occurrence Oct 14 1947

(c) Where did injury occur? Warren Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On farm

While at work? No (Specify type of place) (e) Means of injury hanging

23. Signature Dr. P. H. Huggins (M.D. or other) _____

Address Warrenton Date signed July 10

SUPPLEMENTAL

S-44830