FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 14 1948

Registration District No. 2

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22937

Primary Registration District No. 5476

Registrar's No.

1. PLACE OF DEATH:

(a) County: Grundy

(b) City or town: Tindall
(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 years, months or days)

In this community: 65 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Grundy Co

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No): N

If yes, name country

3. (a) PRINT FULL NAME: Alzylda Brokaw

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: Widowed

6. (b) Name of husband or wife: W. L. Brokaw

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

7. Birth date of deceased: Oct (Month) 14 (Day) 1851 (Year)

8. AGE: Years	Months	Days	If less than one day
96	9	2	hr. min.

9. Birthplace (City, town, or county): (State or foreign country): Ohio

10. Usual occupation: House Wife

11. Industry or business:

FATHER 12. Name: James Henery Brokaw

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

MOTHER 14. Maiden name: unknown

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

16. (a) Informant: Alta Brokaw

(b) Address: Spickard Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-18-1948 (Month) (Day) (Year)

(c) Place: burial or cremation: Proctor Cem. Grundy Co Mo

18. (a) Signature of funeral director: Schooler Funeral Home

(b) Address: Spickard Mo

19. (a) 7-20-48 (Date received local registrar) (b) Irene Fair (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1948 hour 1:30 A.M.

21. I hereby certify that I attended the deceased from July 1st 1948 to July 16 1948 that I last saw her alive on July 16 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to: Hypertension	1 year
Due to: Do not know	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
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):

(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): N

While at work: (e) Means of injury:

23. Signature: Oliver F. Duffy (M.D. or other) M.D.

Address: Trenton Mo Date signed: July 16 1948

(Licensed Embalmer's Statement on Reverse Side)

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Springfield Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44

Registration District No. 132 Primary Registration District No. 5476 Registrar's No.

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Trenton
(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 years, months or days)

In this community

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 Alwylda Brokan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 14 1852
(Month) (Day) (Year)

8. AGE: Years 96 Months 9 Days If less than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7/20/48 (Date received local registrar) (b) Irene Zaun (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 26. year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

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)

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-22937