

No. 2
1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27109
Registrar's No. 24

Registration District No. 244

Primary Registration District No. 5228

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: 1
(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 Mo (b) County New Madrid

(c) City or town Portageville 79
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 6

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Winfred Gale Brandenburg

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race white

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

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

7. Birth date of deceased Aug 22 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 5 min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Tom Brandenburg

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

14. Maiden name Mary Magdalene Copeland

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

16. (a) Informant Tom Brandenburg

(b) Address Portageville, Mo

17. (a) Burial (b) Date thereof 8-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Williams Cemetery

18. (a) Signature of funeral director Family

(b) Address Portageville, Mo

19. (a) 8-23-48 (b) Ellen DeLich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd year 1948 hour 9 minute 25 A.M.

21. I hereby certify that I attended the deceased from Aug 22nd 1948 to Aug 22nd 1948 that I last saw him alive on Aug 22nd 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Strangulation

Due to Disproportion of Pelvic & Abdominal

Due to _____

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

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 John J Killiam (M. D. or other) _____

Address Portageville, Mo Date signed 8-23-48

Duration _____

PHYSICIAN _____

Underline the cause of which death should be charged statistically.

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

RECEIVED
District Health Office No. 2,
District File Number 848-1025
Date Filed 8-28-48

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 with the above constitutes grounds for revocation of license.)

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