

FILED SEP 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26392

BIRTH NO. _____		REG. DIST. NO. <u>61</u>		PRIMARY REG. DIST. NO. <u>4107</u>		Registrar's No. <u>58</u>	
1. PLACE OF DEATH a. COUNTY <u>Cedar</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ElDorado Springs</u> c. LENGTH OF STAY (in this place) <u>2 wks</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chambers Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ElDorado Springs</u> d. STREET ADDRESS (If rural; give location) <u>Route 4</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM E. BRACKENRIDGE</u> a. (First) <u>WILLIAM</u> b. (Middle) <u>E.</u> c. (Last) <u>BRACKENRIDGE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 20, 1949</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 27, 1873</u>	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Robert Thomas Brackenridge</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah E. Gorden</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Josie Brackenridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Thomas Brackenridge, ElDorado Spgs. Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>unknown</u> DUE TO (c) <u>unknown</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>7-31</u> , 19 <u>49</u> , to <u>8-20</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-20</u> , 19 <u>49</u> , and that death occurred at <u>8:45 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. Richardson M.D.</u>				23b. ADDRESS <u>ElDorado Spgs.</u>		23c. DATE SIGNED <u>Aug. 22, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 22, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ElDorado Spgs. Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>ElDorado Springs, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 22, 1949</u>		REGISTRAR'S SIGNATURE <u>per J. E. Krumpholtz</u>		FUNERAL DIRECTOR'S SIGNATURE <u>per J. E. Krumpholtz</u>		ADDRESS <u>ElDorado Spgs.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 7
District File Number 8-49-1048
Date Filed 9-2-49

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4419

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.