

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

17355-a  
71-10.2

1. PLACE OF DEATH

County Henry Registration District No. 200 File No. 17355-a  
Towship \_\_\_\_\_ Primary Registration District No. 2018 Registered No. 71-10.2  
City Clinton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Elizabeth Brandenburg  
(a) Residence No. 216 N. Washington St. 2 Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 15 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>a.y. Brandenburg</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS <u>76</u>	MONTHS <u>8</u>	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work _____				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer _____				

9. BIRTHPLACE (CITY OR TOWN) Watsika  
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER Andrew J. Layton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Sarah Pierce

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Ohio

14. INFORMANT Leartus Leanan  
(Address) Clinton Mo.

15. FILED 7/11, 1921 12 12 12 am  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1921  
17. I HEREBY CERTIFY, That I attended deceased from July 9 1921 to July 9 1921 that I last saw him alive on July 9 1921, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Crosser 7 River  
465 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) T. T. Barr, M. D.  
7/16, 1921 (Address) Clinton Mo.  
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clinton Mo DATE OF BURIAL 7/11 1921  
20. UNDERTAKER Wright + Wilkinson ADDRESS Clinton Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

County..... Registrations District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No.....) St..... Ward.....

2. FULL NAME

(a) Residence, No....., Ward.....  
 (Usual place of abode).....  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY..... (duration)..... yrs. mos. da.  
 (SECONDARY)..... (duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH..... DATE OF.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D  
 , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL..... 19.....

20. UNDERTAKER

ADDRESS