

NOV 19 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35435

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(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 76 years
years, months or days

3. (a) PRINT FULL NAME

AWNAH BROOKS

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 Single

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

7. Birth date of deceased Jan 15 1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation House work

11. Industry or business _____

12. Name Daniel A Brooks

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

14. Maiden name Hannah Echols

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

16. (a) Informant Escav Kumbrough

(b) Address Clinton Mo

17. (a) Burial (b) Date thereof 10-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Good Hope

18. (a) Signature of funeral director Constance Beech

(b) Address Clinton Mo

19. (a) Nov 1, 1940 (b) D. J. K. Sampson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry
(c) City or town Clinton Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 901 N 2ND
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13
year 1940 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased many years
_____ 19 _____ to 10/13 19 40

that I last saw h.e.r. alive on 10-12 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to arterio sclerosis
mitral disease

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 E. C. Peltor M.D. (M.D. or other) _____

Address Clinton Mo Date signed 10/14/40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number

11-40-1640

Date Filed

11-14-40

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

J. E. Coriolis

Licensed Embalmer No.

1891

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, above space should be left blank.