

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

42649
Do not use this space.

FILED JAN 16 1941

1. PLACE OF DEATH

(a) County HENRY Registration District No. 355
 (b) Township DAVIS Primary Registration District No. 5497 Registered No. 28
 (c) City CLINTON (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 0 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME DAVID RICHARD BRAMELL

(a) Residence, No. RURAL St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Vanda M. Brammell
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC. 27 1867
 7. AGE YEARS 72 MONTHS 11 DAYS 23 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER -
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FRANKLIN COUNTY Mo
 FATHER 13. NAME WASHINGTON BRAMELL
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FRANKLIN COUNTY Mo
 MOTHER 15. MAIDEN NAME LOUISA A COLE
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FRANKLIN COUNTY Mo
 17. INFORMANT (ADDRESS) L. A. Brammell Clinton Mo. RFD
 18. BURIAL, CREMATION, OR REMOVAL PLACE Stones Chapel DATE Dec 22 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. S. Gussant Clinton Mo.
 20. FILED 12 21 1940 W. E. Baggarly Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 20 1940
 22. I HEREBY CERTIFY, That I attended deceased from 9-20 1940 to 12-10 1940
 I last saw him alive on 12-10 1940 Death is said to have occurred on the date stated above, at 4:30 A. M.
 The principal cause of death and related causes of importance were as follows:
Thyroiditis
Nephritis
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) James Smith M. D.
 (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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RECEIVED

District Health Officer No. 7,

District File Number 1-41-12

Date Filed 1-3-41

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~~.....

N. A. Gausman

Registered Apprentice No.....

working under my personal supervision.

Signed *N. A. Gausman*

Licensed Embalmer No. 3779

P. O. Address Clinton, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42649

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 355

Primary Registration District No. 5497

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Paris, T. P.
(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 _____ (Specify whether
years, months or days)

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) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME David Richard Bramell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Dec day 20 year 1940 hour _____ minute _____ M.

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

Immediate cause of death myo Carditis
nephritis Chome

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 1/21

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature James O. Smith (M. D. or other) MD

Address Clinton Mo Date signed 2-13-41

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

