

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: 218 W Allen St 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 life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")
(d) Street No. 218 W Allen
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JUNE LEE BRECKENRIDGE

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 11 1945
(Month) (Day) (Year)

8. AGE: Years 1 Months 2 Days 24 If less than one day
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Austin Brecknridge
13. Birthplace Clinton Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Bessie Brecknridge
15. Birthplace Clinton Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Bessie Brecknridge
(b) Address Clinton Mo

17. (a) Burial (b) Date thereof 4 7 46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crowwood Cem

18. (a) Signature of funeral director Fred Williams
(b) Address Clinton Mo

19. (a) 4-7-46 (b) R.R. Kenney
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 5
year 1946 hour 4 minute 00 P. M.
21. I hereby certify that I attended the deceased from 4/5
1946 to 4/5/46
that I last saw her alive on 4/5/46
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 4da.
Due to _____
Due to _____

Other conditions Measles 10da.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 35

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)
Signature R.D. Hall (M.D. or other)
Address Clinton Mo Date signed 4/6/46

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
11840
46

JUL 5 1946

District File No. 4-46-409
Date Filed 5-10-46

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 F. E. Wilkerson

Licensed Embalmer No. 5478

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, fact should be so stated above.