MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County: Bates
Township: OSAGE
City: Rich Hill M (No. ..... St. ..... Ward)

Registration District No.: 53
Primary Registration District No.: 5082

File No.: 3884
Registered No.: 10

2. FULL NAME JAMES Brooks

(a) Residence, No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED,~~ WIDOWED OR ~~DIVORCED (write~~ the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1882-9-15

7. AGE: YEARS 51 | MONTHS 4 | DAYS 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Steel Worker
(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): Mo

PARENTS

10. NAME OF FATHER: Tom Brooks
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): DONT' KNOW
12. MAIDEN NAME OF MOTHER: DONT KNOW
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: Pearl Craig
(Address): Rich Hill Mo

15. FILED 2/14 1934 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/13 1934

17. I HEREBY CERTIFY, That I attended deceased from 2/13-34, 19..., to ....., 19..., that I last saw h..... alive on 2/13-34, 1934, and that death occurred, on the date stated above, at 8 a.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carbon Damage
82A
(duration) ..... yrs. ..... mos. 2 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) R. R. Shafer, M. D.
, 19 (Address) Rich Hill 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Archie Mo
DATE OF BURIAL: 2-14 1934

20. UNDERTAKER: Gooth & Vaughan
ADDRESS: Rich Hill 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Bates — Registration District No. 53 — File No.
Township Osage — Primary Registration District No. 5082 — Registered No. 10
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME James Brooks
(a) Residence, No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19

19. UNDERTAKER (ADDRESS)

20. FILED ....., 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 13, 1934

22. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1934, to Feb 13, 1934
I last saw him alive on 8/12, 1934 Death is said to have occurred on the date stated above, at 5 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral	
Hemorrhage	

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? .....
If so, specify .....
(Signed) R. R. [signature], M. D.
(Address) Rich Hill

SUPPLEMENTARY

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

HEALTH OFFICERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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