

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

REC'D JUL 26 1939

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

23473  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Texas Registration District No. 863  
 (b) Townshp. Piney Primary Registration District No. 6137 Registered No. 19  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Nute Brim

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Ella Brim</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 7th, 1939</u>		
7. AGE YEARS <u>43</u>	MONTHS <u>4</u>	DAYS <u>15</u>
IF LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>W.P.A. Worker</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>W.P.A. Work</u>		
10. Date deceased last worked at this occupation (month and year) <u>June 22d, 1939</u>		
11. Total time (years) spent in this occupation _____		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Shannon County Mo.</u>		
13. NAME <u>R. A. Brim</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>		
15. MAIDEN NAME <u>Addie Stringer</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas Co. Mo.</u>		
17. INFORMANT (ADDRESS) <u>Mrs. Ella Brim Raymondville Mo.</u>		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 22d, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 9-30 A.M.  
 The principal cause of death and related causes of importance were as follows:

Killed by lightning while leaning against tree

Date of onset

Other contributory causes of importance:

1424

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? Yes  
 If so, specify \_\_\_\_\_  
 (Signed) J. H. Starnes M. D.  
 (Address) Houston Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Friend Ship Comp DATE June 23d, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. V. Elliott Houston Mo.  
 20. FILED July 3, 1939 Mable Shacklett Local Registrar.

**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.....

*Gaylord V. Elliott*

Licensed Embalmer No.....

2252

P. O. Address.....

Houston 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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

23473

Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 863  
(b) Township Pikey Primary Registration District No. 6137 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mute Brim

(a) Residence, No. \_\_\_\_\_ 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-7-1939 <sup>1895</sup>

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
43 4 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
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) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

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

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED July 3 1939 Mabel Shacklett Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-22 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

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) J. R. Womack, M.D.  
(Address) Houston Mrs.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
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.

SUPPLEMENTARY

