

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

39
B
6

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

OCT 12 1938

32428
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township 1 Primary Registration District No. 2001 Registered No. 723
 (c) City SPRINGFIELD (d) Street No. 811 W Scott 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 620 Harry R Brooks
 (a) Residence, No. 811 W Scott 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minnie Brooks

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 2, 1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
✓	61	5	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk
 9. Industry or business in which work was done, as saw mill, bank, etc. Wolfe's Store
 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) Lock Springs Mo.

FATHER

13. NAME Henry Brooks 0
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England 4

MOTHER

15. MAIDEN NAME O Lellia Fischer
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

17. INFORMANT (ADDRESS) Mrs. Manning Brooks Springfield, Mo.

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

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Johnson Springfield, Mo.

20. FILED Sept 25 1938 Chas. A. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 19 39 to Sept 24 39
 I last saw him alive on Sept 25 39 19__ Death is said to have occurred on the date stated above, at 7:40 A.M.
 The principal cause of death and related causes of importance were as follows:

	Date of onset
<u>Chr. Glomerulo-nephritis</u>	<u>1932</u>
<u>C uremia</u>	<u>June 30</u>

Other contributory causes of importance: - 34
Syphilis

Name of operation _____ Date of _____
 What test confirmed diagnosis? N.P.N. Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No. 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) R. M. Rigney, M. D.
 (Address) Shallard Bldg. Springfield Mo.

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.....

Chas. L. George....., Registered Apprentice No. *204*
working under my personal supervision.

Signed..... *Harlow Kriehl*.....

Licensed Embalmer No. *4065*.....

P. O. Address..... *Springfield 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.

J