

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.

Dr. Busch

36079

Do not use this space.

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

1. PLACE OF DEATH **GREENE** Registration District No. **318**

(a) County **GREENE** Primary Registration District No. **2001** Registered No. **769**

(b) Township _____

(c) City **SPRINGFIELD** (d) Street No. **801 S. Pickwick** 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 **Charlotte Mae Brock**

(a) Residence, No. **801 S. Pickwick** St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Child</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Dec 23, 1928</i>		
7. AGE YEARS <i>10</i>	MONTHS <i>9</i>	DAYS <i>26</i>
IF LESS than 1 day, _____ hrs. per _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>In school</i>	
	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 <input checked="" type="checkbox"/>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>N. City Mo.</i>		
FATHER	13. NAME <i>Charles C. Brock, Jr.</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>N. City Missouri</i>	
MOTHER	15. MAIDEN NAME <i>Mary Elizabeth Clevers</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis, Mo.</i>	
17. INFORMANT (ADDRESS) <i>Charles C. Brock, Jr. 801 S. Pickwick, City</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Leavenworth, Mo.</i> DATE <i>10-29-39</i>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <i>Alma Schmeier Springfield, Mo.</i>		
20. FILED <i>Oct 31 1939</i> <i>Chas. A. Morgan</i> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 19, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *4-1*, 19*39*, to *6-3*, 19*39*.

I last saw her alive on *06-3*, 19*39*. Death is said to have occurred on the date stated above, at *12:15 P.M.*

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

Date of onset

Nephritis

General edema

Other contributory causes of importance:

Edema of Brain

Renal secondary

Name of operation _____ Date of _____

What test confirmed diagnosis? *Blood & Urine examination*

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) *Carlton J. Busch*, M. D.

(Address) *Springfield, Mo.*

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143M

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 Lewis G. Scharpf

Licensed Embalmer No. 3802

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.

X

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36079
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 769
 (c) City Springfield (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

Charlotte Mae Brock
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child

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.
	<u>10</u>	<u>9</u>	<u>26</u>	

OCCUPATION
 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) _____

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. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 12-14-39 Chas O George MD Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 19 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:

Neuritis chronic Date of onset _____
General Edema
Edema of Brain
Anemia Secondary

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) Urban J Busien, M. D.
 (Address) Springfield

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

SUPPLEMENTARY

