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.

DEC 11 1939

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

39100
Do not use this space.

3

1. PLACE OF DEATH
(a) County Buchanan 1 Registration District No. 85
(b) Township ..... Primary Registration District No. 1001 Registered No. 1234
(c) or City St Joseph Mo (d) Street No. State Hosp. #2 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. 9 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 550 Maurine Inman
(a) Residence, No. State Hospital #2 St. Brookfield Mo.
(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 Female
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 —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 5 1903
7. AGE YEARS 36 MONTHS 3 DAYS 24 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house mail
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) Linn Co. Mo. 0

FATHER
13. NAME Frank Inman 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? 0

MOTHER
15. MAIDEN NAME Della Woods
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Mo.

17. INFORMANT (ADDRESS) Frank Inman, Brookfield, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Brookfield, Mo DATE 12-1 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rusk Funeral Home Brookfield, Mo
20. FILED 11/30/39 19 H. J. Hestlehurst Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 29, 1939
22. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1939 to Nov. 29, 1939
I last saw her alive on Nov. 29, 1939 Death is said to have occurred on the date stated above, at 6:45 P.m.
The principal cause of death and related causes of importance were as follows:

Broncho-pneumonia — Date of onset 11/25/39

1070

Other contributory causes of importance:

~~broncho pneumonia~~ 11/25/39

Name of operation none Date of —
What test confirmed diagnosis? Clinical Was there an autopsy? NO

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? NO
If so, specify .....
(Signed) T. T. O'Dell, M. D.
(Address) St. Joseph,

(Licensed Embalmer's Statement on Reverse Side)

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.....H. R. Wright

Licensed Embalmer No.....3718

P. O. Address.....Brookfield, Ma

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.