

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 467

Primary Registration District No. 4280

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Aurora
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Shirley Bruffett 6.13
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 30 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Aurora Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Bill Bruffett
13. Birthplace Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Neva McClelland
15. Birthplace Stone County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address Aurora Mo.

17. (a) Burial (b) Date thereof 2 20 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Marionville Mo.

18. (a) Signature of funeral director John King
(b) Address Aurora Mo. 418

19. (a) 2-21-40 (b) R. L. Cowan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19 year 1940 hour 1 minute 30 P. A. M.

21. I hereby certify that I attended the deceased from Feb 15 1940 to Feb 18 1940
that I last saw her alive on Feb 18 1940
and that death occurred on the date and hour stated above

Immediate cause of death Bronchial pneumonia Duration 4 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. J. Smith (M. D. or other) 1
Address W. Pleasant Aurora Date signed 2/20/40

PHYSICIAN
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

109K

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
BUREAU OF HEALTH CARE REGULATION

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.....

Not Embalmed,....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7158**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **467**

Primary Registration District No. **4280**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County **Lawrence**
(b) City or town **Laurora**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Shirley Bruffett**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased **Nov - 30 - 1939**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 19 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb** day **19**
year **1970** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia
w/ complications**

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death) **1970**

Major findings:
Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work?..... (Specify type of place) Means of injury.....

23. Signature **J. Nell Smith** (M. D. or other).....

Address **Laurora** Date signed.....

SUPPLEMENTAL

S-7158