DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11081

FILED APR 8 1940

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dr. Wetzel Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Clinton, Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 921-N-4th (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Minerva Louise Brady
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race Colored
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife George E. Brady
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased Oct. (Month) 15 (Day) 1898 (Year)

8. AGE: Years 41 Months 5 Days 17 If less than one day hr. min.

9. Birthplace Clinton (City, town, or county) Mo. (State or foreign country)
10. Usual occupation V
11. Industry or business V

FATHER
12. Name Wiley Shockley
13. Birthplace Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hattie Mills
15. Birthplace Clinton (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Geo. E. Brady
(b) Address 921-N-4th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-40 (Month) (Day) (Year)
(c) Place: burial or cremation Colored Cemetery

18. (a) Signature of funeral director Hyatt Son
(b) Address Clinton Mo.

19. (a) 4-6-40 (Date received local registrar) (b) Dr. J. R. Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
year 1940 hour 12 minute M.

21. I hereby certify that I attended the deceased from Mar. 23, 19 40, to Apr 2, 19 40, that I last saw h alive on April 2, 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Post operative Shock	
Due to Hysterectomy V	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operation Fibroma uteri V
Impacted appendix V
Of autopsy

PHYSICIAN
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) (e) Means of injury

23. Signature Geo E Brady (Informant or Brother)
Address Clinton Mo. Date signed Apr 4 1940

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Irven N. Anderson

Licensed Embalmer No. 3641

P. O. Address Clinton, Mo

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

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

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No. 2B
2-21-40
I X22659

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

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(a) County Henry
(b) City or town Clinton
(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 years, months or days) In this community

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.

3. (a) PRINT FULL NAME Minerva Louise Brady
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race Col | 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 41 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation maid
11. Industry or business Private home

MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) 4-6-40 (Date received local registrar) (b) W. J. B. Hampton (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 2
year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

23. Signature Geo. L. Wetzel (M. D. or other)
Address Clinton Mo. Date signed

. No. 2B
—2-21-40
1 X22659

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(c) Name of hospital or institution:
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(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

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.

3. (a) PRINT FULL NAME Minerva Louise Brady

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

4. Sex F 5. Color or race Col 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 31 Months 5 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 2 year 1940 hour minute M.

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

Immediate cause of death Post operative Shock. Duration
Due to Hysterectomy 5419-
Due to Was operated for Hemorrhage 11. 11. 10.
Other conditions There was (Include pregnancy within 3 months of death)
Major findings: Of operations No Malignancy
Of autopsy

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

23. Signature Gus S. Wetzel Do. M.D. or other
Address Clinton Mo. Date signed