

FILED APR 8 1940

Registration District No. 774

Primary Registration District No. 4465

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Flat River
(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 _____ years, months or days 6 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Flat River
(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 Nettie Jane Bruce
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 18th day Feb year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Jan 1938 to Feb 10, 1940
that I last saw her alive on Feb 9, 1940
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Andrew Bruce 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased June 30 1879
(Month) (Day) (Year)

Immediate cause of death Brochoetaria Ch. myocarditis Duration _____

8. AGE: Years 70 Months 8 Days 7 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace unknown (City, town, or county) (State or foreign country)
10. Usual occupation at home
11. Industry or business _____
12. Name Samuel H. Gamm
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Ormay Williams
15. Birthplace unknown (City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) ~~Deceased's own signature~~ Andrew Bruce
(b) Address Flat River mo
17. (a) _____ (b) Date thereof 2-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Parkview Cemetery
18. (a) Signature of funeral director Loedwell Buz
(b) Address Flat River mo
19. (a) Feb 10 1940 C. B. Harrar
(Date received local registrar) (Registrar's signature)

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 C. H. Applebury (M. D. or other) MD
Address Flat River Mo Date signed 2-12-40

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.

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.....

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. 12250

Registrar's No. 933

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 774

Primary Registration District No. 4465

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

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Flat River
(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 Nettie Jane Bruce

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

4. Sex 7 5. Color or race w 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 June 3 - 1879
(Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days 7 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

(9) (a) 2-12-40 (b) [Signature]
(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 July day 10
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that last saw h. _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 C. H. Appleberry (M. D. or other) _____

Address Flat River _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1940
S-12250