No. 2
10-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 13 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

14793

State File No.

Registration District No. 289

Primary Registration District No. 4173

Registrar's No. 27

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

1. PLACE OF DEATH:

(a) County Dunklin Co.

(b) City or town Malden, Mo.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin

(c) City or town Malden
(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 Virginia Mae Brashier

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race wht.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cecil Brashier

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased July (Month) 26 (Day) 1920 (Year)

8. AGE: Years 19 Months 8 Days 7 If less than one day hr. min.

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

10. Usual occupation Shirt factory employee

11. Industry or business

FATHER
12. Name Edward Trinkler
13. Birthplace St. Louis Missouri (City, town, or county) (State or foreign country)

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

16. (a) Informant Cecil Brashier
(b) Address Malden, Mo.

17. (a) ~~Malden~~ Burial (Burial, cremation, or removal) (b) Date thereof 4 (Month) 4 (Day) 1940 (Year)
(c) Place: burial or cremation Malden, Mo.

18. (a) Signature of funeral director W. L. Craig
(b) Address Malden Mo.

19. (a) 4/3/1940 (Date received local registrar) (b) S. E. Mitchell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd year 1940 hour 1 AM minute A M.

21. I hereby certify that I attended the deceased from March 19, 1940 to April 3, 1940 that I last saw her alive on April 2, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Oedema	1 wk
Due to Eclampsia	1 wk
Due to Pregnancy	6 mo
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? 2 (Specify type of place)
While at work? (e) Means of injury

23. Signature Homer Beall (M. D. ~~or other~~)
Address Malden Mo Date signed 4/3/40

(Licensed Embalmer's Statement on Reverse Side)

MAR 22 1948

RECEIVED
District Health Officer
District File Number 540-10
Date Filed 5/9/4

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 U. H. Craig

Licensed Embalmer No. 2850

P. O. Address Malden 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.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14793

Registration District No. 289 Primary Registration District No. 4173 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Malden
(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)

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 Virginia Mae Brashier

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 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 19 Months 8 Days 7 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 3 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 Pulmonary Oedema. Eclampsia

Due to Pregnancy

Due to Premature (7 mo) Spontaneous delivery during Convulsion

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 146
Of autopsy

Duration 3/4/1940

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 Homer Beall (M. D. or other)
Address Malden Mo Date signed

S-14793