

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.

Registration District No. 124

Primary Registration District No. 4070

Registrar's No. 18

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Jackson Mo
 (c) Name of hospital or institution: 2
 (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

3. (a) PRINT FULL NAME Charles W. Brunnecke
 (b) If veteran, name war _____
 (c) Social Security No. None

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lutie Brunnecke
 6. (c) Age of husband or wife if alive 69 years
 7. Birth date of deceased Dec 13 1860
 (Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 1
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Mo Pacific Railway

MOTHER FATHER
 11. Industry or business _____
 12. Name Louis Brunnecke
 13. Birthplace Ironton Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Ross
 15. Birthplace Ironton Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank S. Rogers
 (b) Address Jackson Mo

17. (a) Buried (b) Date thereof May 16 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson City Line
 (d) Signature of funeral director J. C. Beauchamp

(b) Address Jackson Mo
 19. (a) 5-16-40 (b) D. G. Seiber
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Cape Gir
 (c) City or town Jackson Mo
 (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 May day 14
 year 1940 hour 10:30 minute 30 a. M.
 21. I hereby certify that I attended the deceased from May 5
 to May 14 1940
 that I last saw him alive on May 14 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Intestinal
Typhoid
 Due to arterio sclerosis many years

Due to Chronic Prostatitis many years
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: 121
 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?
100

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

23. Signature D. G. Seiber (M. D. or other) PHM
 Address Jackson Mo Date signed 5-15-40

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. **18090**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **124**

Primary Registration District No. **4070**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
(b) City or town **Jackson, 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)

3. (a) PRINT FULL NAME **Charles W. Brewnecke**

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

4. Sex **m** 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 **79** Months **5** Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____

19. (a) **5-16-40** (b) **D. G. Leibert**
(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 **May** day **14** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ 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 **D. G. Leibert** (M. D. or other) _____

Address **Jackson, Mo** _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-18090