

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24801**
Registrar's No. **241**

Registration District No. **125** Primary Registration District No. **3009**

1. PLACE OF DEATH:
(a) County **Cape Girardeau**
(b) City or town **" " "**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hosp. **1**
(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 **Denia Brands** **653**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 16 1885**
(Month) (Day) (Year)

8. AGE: Years **55** Months **3** Days **0** If less than one day _____ hr. _____ min.

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

10. Usual occupation **WOMAN**

11. Industry or business _____

MOTHER FATHER
12. Name **John Brauer**
18. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Louise Thiel**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **John Brands**
(b) Address **Portageville Mo**

17. (a) **Burial** (b) Date thereof **7-18-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Portageville, Mo.**

18. (a) Signature of funeral director **Brinkley Howell**
(b) Address **Cape Girardeau, Mo**

19. (a) **7-16-40** (b) **Jim Thompson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Portageville, 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 **July** day **16**
year **1940** hour **I** minute **15** pm.

21. I hereby certify that I attended the deceased from **July 15**, 19**40**, to **July 16**, 19**40**
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **STUNNATED VENTRAL HERNIA**
Due to _____
Due to **operated**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **Gangrenous Intestines**
Of operations _____
Of autopsy **NO**

Duration _____
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? **121**
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Ad Smith** (M. D. or other) **MD**
Address **Cape Girardeau** Date signed **7/16/40**

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.