

S. No. 2  
-11-10-39  
-4-17-39  
WI X21

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27792**

Registration District No. **1**

Primary Registration District No. **1**

Registrar's No. **199**

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

**1. PLACE OF DEATH:**  
 (a) County Adair  
 (b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Grim-Smith  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Thomas Brawner 656  
**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** Married

**6. (b) Name of husband or wife** Sarah Nancy **6. (c) Age of husband or wife if alive** \_\_\_\_\_ **years**

**7. Birth date of deceased** Oct. 28 1869  
(Month) (Day) (Year)

**8. AGE:** Years 70 Months 9 Days 13 **If less than one day** \_\_\_\_\_ **hr.** \_\_\_\_\_ **min.** \_\_\_\_\_

**9. Birthplace** Adair Co., Mo. **(City, town, or county)** \_\_\_\_\_ **(State or foreign country)** 0

**10. Usual occupation** Farming

**11. Industry or business** Farming

**MOTHER FATHER**  
**12. Name** John S. Brawner **13. Birthplace** Unknown  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Nancy McBrady **15. Birthplace** Unknown  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Pearl McCabe  
**(b) Address** Novinger, Mo. R. R. #1

**17. (a) Burial** \_\_\_\_\_ **(b) Date thereof** 8-13-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Maple Hills

**18. (a) Signature of funeral director** Dee Riley  
**(b) Address** Kirksville Mo.

**19. (a) Date received local registrar** Sept 2/40 **(b) Registrar's signature** Spencer L. Freeman

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State 0 Missouri (b) County Adair  
 (c) City or town "Rural"  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Greentop, Mo. R. R. #2  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ **years.**

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month August day 10<sup>th</sup>  
 year 1940 hour 5<sup>00</sup> minute 50 **P. M.**

**21. I hereby certify that I attended the deceased from** Aug 7 1940  
Aug 10 to Aug 10, 1940  
 that I last saw him alive on Aug 10, 1940  
 and that death occurred on the date and hour stated above.

**Immediate cause of death** Myocardial failure **Duration** 3 days

**Due to** Ruptured Gb & peritonitis **Duration** 1 week

**Due to** Cholecystitis & stones **Duration** over year

**Other conditions** attacks of lethargy **Duration** 1 1/2 years  
(Include pregnancy within 9 months of death)

**Major findings:**  
**Of operations** Ruptured Gb with peritonitis & Gall stones  
**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? \_\_\_\_\_

**3** While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

**23. Signature** George E. Gamm **(M. D. or other)** MD  
**Address** Yankasville Mo **Date signed** 8-20-40

RECEIVED

District Health Officer No. 10

District File Number 9-40-1726

Date Filed SEP 10 1940

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 *J. E. Riley*

Licensed Embalmer No. *3908*

P. O. Address *Kentville MD*

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.