

o. 2
-10-39
7-39
X21492

Registration District No. 266

Primary Registration District No. 2370

Registrar's No. 61

1. PLACE OF DEATH:

(a) County De Witt Co. Mo.
(b) City or town Rural Springcreek Twp
(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 2
(Specify whether
In this community _____
years, months or days) (70)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Witt
(c) City or town Springcreek Rural
(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 JOSEPH DAVID B. BRESSIE

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Bessie 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased: Dec (Month) 19 (Day) 60 (Year)

8. AGE: Years 79 Months 8 Days 7 If less than one day hr. _____ min. _____

9. Birthplace De Witt Co Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name David Bessie

13. Birthplace France (City, town, or county) (State or foreign country)

14. Maiden name Lulanda Sullivan

15. Birthplace Georgia (City, town, or county) (State or foreign country)

16. (a) Informant J. C. Bressie

(b) Address 3718 Bates St. St. Louis

17. (a) _____ (b) Date thereof 8 8 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove Cemetery

18. (a) Signature of funeral director Hobbes Cranham

(b) Address Salem Mo

19. (a) Aug 9 - 1940 (b) F. E. Kuttler MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7th year 1940 hour 5 P.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from Aug 1, 1940, to Aug 7, 1940.

that I last saw him alive on Aug 7, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

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 B. E. Joseph (M. D. or other) MD

Address Salem, Mo Date signed 8/9/40

Duration unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

0756

July

RECEIVED

District Health Officer No. 5,

District File Number 940936

Date Filed _____

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 _____

N D Hobson

Registered Apprentice No. _____

working under my personal supervision.

Signed *N D Hobson*

Licensed Embalmer No. 928

P. O. Address Salem, Mass

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.