

NOV 20 1940

STANDARD CERTIFICATE OF DEATH

State File No. 35700

Registration District No. 472

Primary Registration District No. 5633

Registrar's No. 126

1. PLACE OF DEATH:

(a) County Lawrence Co
 (b) City or town New Vernon Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: X
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution X
 In this community 75 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
 (c) City or town New Vernon Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME

Frank Roberts Brackinridge

MEDICAL CERTIFICATION

29. DATE OF DEATH: Month Oct day 4
 year 1940 hour 3 minute 08 a M

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

21. I hereby certify that I attended the deceased from 7-28, 1940, to 7-28, 1940;

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 8

that I last saw him alive on 7-28-40, 1940; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

Immediate cause of death Hemorrhage - B. Artery

7. Birth date of deceased April 2 1854
 (Month) (Day) (Year)

Due to Erosion Squamous cell Carcinoma

8. AGE: 82 Years 6 Months 2 Days If less than one day hr. min.

Due to metastases to lymph nodes

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Farmer

Major findings: Of operations

11. Industry or business X

12. Name F. W. Brackinridge

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

14. Maiden name Charlotte E. Whalen

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

16. (a) Informant Charles Brackinridge

(b) Address New Vernon Mo

17. (a) Burial (b) Date thereof 10 6 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mo City

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? 421
 While at work (Specify type of place) (e) Means of injury

23. Signature Kenneth Glover (M. D. or other) !

Address New Vernon, Mo Date signed 10-5-40

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

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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 *George B. Orr*

Licensed Embalmer No. *946*

P. O. Address *Mr Vernon*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-700**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **470**

Primary Registration District No. **5633**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **St. James**
(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

Frank R. Brackenkedge

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 **s**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **82** Months **6** Days **2** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____
(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 _____ day _____
year _____ 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 **Hemorrhage of axillary artery**
eroding squamous cell carcinoma metastases to lymph nodes
Due to **57**
Other conditions **carcinoma cell**
(Include pregnancy and its results)
Major findings **Cap of abscess of ret.**
Of operations **lymph nodes with metastases to lymph nodes in axilla**

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?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

