

38005

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

5-17-39
X23159

DEC 5-1940
13

Primary Registration District No. 5017 205 Registrar's No. 43

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

1. PLACE OF DEATH:

(a) County Andrew

(b) City, or town Rural Jefferson Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rural Route #2, East Savannah Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 70 years (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME Louise Mary Brandt

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 widowed

6. (b) Name of husband or wife Fred

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased January 25 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER { 12. Name John Jasberg 6

13. Birthplace Unknown Germany 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary Unknown

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

16. (a) Informant L. Brandt

(b) Address East Savannah Road, R. F. D. #2

17. (a) burial (b) Date thereof October 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Ashland Cemetery

18. (a) Signature of funeral director St. Joseph, Missouri Walter Meisberger

(b) Address 1302 Faron, St. Joseph, Missouri

19. (a) Oct. 22-40 (b) Mrs. Jennie Rash
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Andrew

(a) State Missouri (b) County Buchanan

(c) City or town Rural Jefferson Township
(If outside city or town limits, write "RURAL")

(d) Street No. R. F. D. #2, East Savannah Road
(If rural, give location)

(e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20
year 1940 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 9 1940 to Oct. 20 1940, that I last saw et alive on Oct. 10 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Ursemia

Due to Brite disease

Due to Arthritis deformans

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? 034

(Specify type of place) _____
(e) Means of injury _____

23. Signature Willard B. Kelly (M. D. or other) md.
Address Savannah, Missouri Date signed 10-22-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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..... *W. A. Kelly*
Licensed Embalmer No. *Mo. 3946*

P. O. Address *St. Joseph, Missouri.*

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. 38005
Registrar's No. 43

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 2

Primary Registration District No. 205

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Jefferson
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Louise Mary Brandt

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
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 Months Days If less than one day
76 8 25 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) _____ (Registrar's signature)

(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 Oct day 20
year _____ 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 uremia
Bright's disease
chronic
arthritis
Other conditions _____ (Include pregnancy within 3 months of death) 121

Major findings:
Of operations _____
Of autopsy _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

