

FILED SEP 10 1941 H 2  
Registration District No. \_\_\_\_\_

Primary Registration District No. 10614

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural Hooker 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 1 (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED: 053

(a) State Mo (b) County Laclede 0

(c) City or town Rural Hooker Twp  
(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.? 0 years.

3. (a) PRINT FULL NAME Elsie Mae Broyles

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1941 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from July 19, 1941 to July 30, 1941  
that I last saw her alive on July 30, 1941  
and that death occurred on the date and hour stated above.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Frank M. Broyles

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

7. Birth date of deceased Aug 11 1889  
(Month) (Day) (Year)

Immediate cause of death: Bronchial pneumonia Duration 1 day

Due to Cancer Gall bladder unknown

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 46

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>11</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Joseph Brennan

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

14. Maiden name Annie Hays

15. Birthplace Red Rock Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank M. Broyles

(b) Address Lebanon Market Creek Rt

17. (a) burial (b) Date thereof Aug 1 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Balles Cemetery

18. (a) Signature of funeral director W. E. HOLMANN

(b) Address Lebanon, Mo.

19. (a) Aug 9-1941 (b) Josephine Martin  
(Date of local registrar) (Registrar's signature)

Major findings: Of operations none

Of autopsy none

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 James L. Hope (M. D. or other) P  
Address Lebanon, Mo. Date signed 7/31/41

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 9-41-1629

Date Filed 9-9-41

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.....

Myself....., Registered Apprentice No.....  
working under my personal supervision.

Signed Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon mo.

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.