V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 22 1942

Registration District No. 566

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5762

State File No. 42517

Registrar's No. 130

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

1. PLACE OF DEATH:

(a) County: Mississippi Township or Twp

(b) City or town: ~~Charleston (Rural)~~
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1mile northeast of Charleston.
(If not in hospital or institution, write street number or location)

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

In this community: 24 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Mississippi

(c) City or town: Charleston, Mo.
(If outside city or town limits write "RURAL")

(d) Street No.: 1 mile northeast of Charleston
(If rural, give location)

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

3. (a) PRINT FULL NAME: John Calvin Brooks

3. (b) If veteran, name war: XXX

3. (c) Social Security No. 489-18-6994

4. Sex: Male 2

5. Color or race: Colored

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

6. (b) Name of husband or wife: Florene Brooks

6. (c) Age of husband or wife if alive: 22 years

7. Birth date of deceased: May (Month) 1 (Day) 1911 (Year)

8. AGE: Years 30 | Months 7 | Days 18 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Compress Worker

11. Industry or business: XXX

FATHER
12. Name: Sylvester Brooks
13. Birthplace: Penola (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name: Mattie Smith
15. Birthplace: Penola (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant: Sylvester Brooks
(b) Address: Charleston, Mo. Gen. Del.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/19/1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Grove Cemetery

18. (a) Signature of funeral director: Carl J. Reinsdeer
(b) Address: Charleston, Missouri.

19. (a) 12-21-41 (Date received local registrar) (b) F. S. Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19 year 1941 hour 4 minute a 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: Tuberculosis

Duration: 12 mo

Due to:

Due to:

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

Major findings:
Of operations:

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

23. Signature: Paul S. Barnes M.D. (M. D. or other)
Address: Charleston Mo Date signed 12/19/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 142 - 8.0
Date Filed 1-16-42

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42517

Registration District No. 566 Primary Registration District No. 5762 Registrar's No.

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: Rural
(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 (Specify whether years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: John C. Brooks
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: B
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: May (Month) 1 (Day) 19[illegible] (Year)

8. AGE: Years 30 Months 7 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1941 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.

	Duration
Immediate cause of death: Tuberculosis	
Due to: Lungs	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 13 Pl	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: [illegible] Baur (M. D. or other)
Address: Charleston Mo Date signed 3/1/42

SUPPLEMENTARY