

FILED MAY 6 1942

State File No. ....

Registration District No. 221

Primary Registration District No. 5299

Registrar's No. 21

1. PLACE OF DEATH:  
(a) County **Cooper**  
(b) City or town **"Rural" Kelley**  
(c) Name of hospital or institution:  
**4 Miles North Syracuse, Mo**  
(d) Length of stay: In hospital or institution **None**  
In this community **Life**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Cooper**  
(c) City or town **Oterville, "Rural"**  
(d) Street No. **4 Miles North Syracuse, Mo**  
(e) Citizen of foreign country? **Native**

3. (a) PRINT FULL NAME **Wilbur Newton Brubaker**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **August, 25th 1902**

8. AGE: Years **39** Months **8** Days **4** If less than one day hr. **--** min.

9. Birthplace **Cooper County Missouri**

10. Usual occupation **Artist**

11. Industry or business **Painting**

12. Name **Elmer Brubaker**

13. Birthplace **Cooper County Missouri**

14. Maiden name **Gertrude Cordry**

15. Birthplace **Cooper County, Missouri**

16. (a) Informant **Gertrude Brubaker**

(b) Address **Oterville, Mo. R.F.D.**

17. (a) **Removal** (b) Date thereof **4/29/42**

(c) Place: burial or cremation **Bathelham Cemetery**

18. (a) Signature of funeral director **Jessie E. Richards**

(b) Address **Tipkay, Mo.**

19. (a) **Apr 29-1942** (b) **Emilio W. Robin**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **29th** year **1942** hour **1** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **April 14** 1942 to **April 29** 1942 that I last saw him alive on **April 29** 1942 and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis** **starvation**

Duration **5 days**  
**10 days**

Due to **starvation**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature **Theodore W. Doll** (M.D. or other) **D.O.** Address **Syracuse Mo.** Date signed **4/29/42**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8;

District File Number.....

Date Filed 5-2-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>will be</sup> embalmed by me, or by me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Jessie E. Richards  
Licensed Embalmer No. 2466  
P. O. Address Dipton, Ill.

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.

Registration District No. 221

Primary Registration District No. 5299

1. PLACE OF DEATH:

(a) County Cooper  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

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 Wilbur N. Brubaker  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr Day \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 25 1904  
(Month) (Day) (Year)

Duration \_\_\_\_\_

8. AGE: Years 39 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
hr.

Starvation  
Due to leukemia approx 14 yrs.  
(Type of Dementia Presen)

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

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry of business \_\_\_\_\_

Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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)

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Theodore Wm Doll (M.D. or other) D.O.  
Address Springer mo Date signed 6-1-42

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

SUPPLEMENTARY

MOTHER FATHER

