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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED OCT 9 1942

Registration District No. 74

Primary Registration District No. 5-295

Registrar's No. 30-39

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Rural - Council Spring  
(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 50 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

(c) City or town Rural  
(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.

3. (a) PRINT FULL NAME John Vernon Bronenburg

(b) If veteran, name war no

(c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14  
year 1942 hour ? minute ? M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married widowed  
divorced \_\_\_\_\_

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

7. Birth date of deceased March 13 1878  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from none \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on none \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>6</u>	<u>0</u>	_____ hr. _____ min.

Immediate cause of death

(a) Spontaneous Hemorrhage

(b) Coronary Occlusion

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

10. Usual occupation Faberman

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

Due to (a) Alcoholism

Other conditions none  
(Include pregnancy within 3 months of death)

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

12. Name Wm. H. Bronenburg

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

14. Maiden name Elizabeth C. White

15. Birthplace West Virginia  
(City, town, or county) (State or foreign country)

Major findings:

Of operations none

Of autopsy none

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

16. (a) Informant Sarah Jane Bronenburg  
(b) Address Halt Mo.

17. (a) Burial (b) Date thereof 9-17-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg Mo.

18. (a) Signature of funeral director O'Brien - Lyon  
(b) Address Plattsburg Mo.

19. (a) Sept 14 42 (b) md a C Harrell  
(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? \_\_\_\_\_

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

23. Signature [Signature]  
Address Plattsburg Mo Sept 15 42

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

25  
0  
0

*Don't know name*

**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 *Donald W. Lyon*

Licensed Embalmer No. *3640*

P. O. Address *Plattsburg 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.**

Registration District No. 74

Primary Registration District No. 529J

1. PLACE OF DEATH: Clinton

(a) County.....

(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 John Vernon Drownburg

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.....

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 64 Months 6 Days 9 If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day..... year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Stroke Hemorrhage  
Complication of alcoholism  
acute alcoholism

Due to.....

Due to alcoholism

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations..... 77c

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)

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

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

23. Signature [Signature] Date Oct 21 42

Address.....

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

SUPPLEMENTARY

W. B. SPALDING, M. D.

PLATTSBURG, MISSOURI

Oct 21-42

This man was found dead  
in his home on a farm  
where he was living alone.

On further investigation  
I find he had been in-  
toxicated for a week.

I revise my cause of death  
as Acute Alcoholism.

W. B. Spalding

Orange Clinton Co. Mo.