

No. 1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5646**

FILED FEB 19 1943
Registration District No. _____

Primary Registration District No. **5007**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County Adair Rural

(b) City or town Salt River Township

(c) Name of hospital or institution: none

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town RURAL

(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME BRADLEY DEAN ROBERTSON

3. (b) If veteran, name war _____ **3. (c) Social Security** No. ---

4. Sex M **5. Color or** W **6. (a) Single, widowed, married,** Divorced

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____

7. Birth date of deceased Nov. 29 1942

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>2</u>	<u>21</u>	hr. _____ min.

9. Birthplace ADAIR MISSOURI

(City, town, or county) (State or foreign country)

10. Usual occupation ---

11. Industry or business ---

MOTHER FATHER

12. Name "UNKNOWN"

13. Birthplace ---

(City, town, or county) (State or foreign country)

14. Maiden name FRANCES ROBERTSON

15. Birthplace BRASHEAR MISSOURI

(City, town, or county) (State or foreign country)

16. (a) Informant Frances Robertson

(b) Address Brashear, Mo

17. (a) burial (b) Date thereof Jan 21/43

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brashear Cemetery

18. (a) Signature of funeral director Brashear, Mo

(b) Address Brashear, Mo

19. (a) Jan 26 1943 (b) Mr. J. H. Waggers

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January, day 20

year 1943 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from January 18 1943 to Jan. 20 1943

that I last saw him alive on January 20 1943

and that death occurred on the date and hour stated above.

Immediate cause of death BRONCHIAL PNEUMONIA

Duration _____

Due to _____

Due to _____

Other conditions _____

(Includes 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury ---

23. Signature N. E. Constable (M. D. or other) DO

Address Brashear Mo Date signed 1/23/43

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

1047

RECEIVED

District Health Office No. 10

District File Number 2-43-393

Date Filed FEB 16 1943

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.....

Geoffrey W. Hurdson

Licensed Embalmer No. 3755

P. O. Address.....

Hurdson 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5646
Registrar's No. 23

Registration District No. 1

Primary Registration District No. 1007

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Rural
(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 Mo (b) County Adair
(c) City or town Rural
(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 Bradley D. Robertson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
that I first saw him _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death Bronchial pneumonia

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 Nov. 29 (Month) (Day) (Year)

Due to Malnutrition
Due to Throat deformity
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years _____ Months 2 Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

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)

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?
(Specify type of place) _____
While at work? _____ (e) Means of injury 2

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) 4/3/43 (b) Mrs. J. L. Wayard
(Date received local registrar) (Registrar's signature)

23. Signature N. E. Cornettable (M. D. or other) Do
Address BRASHEAR, MO. Date signed 4/3/43

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

SUPPLEMENTARY

MOTHER FATHER

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

