No. 2
1-4-41
5-17-39
X2838

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14659

Registration District No. 170 Primary Registration District No. 5627 Registrar's No.

53 0 0

1. PLACE OF DEATH:
(a) County: LACLEDE
(b) City or town: RURAL FRANKLIN TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: OAKLAND MO
(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: ALWAYS

2. USUAL RESIDENCE OF DECEASED: 53 0 0
(a) State: MO (b) County: LACLEDE
(c) City or town: RURAL
(If outside city or town limits, write "RURAL")
(d) Street No.: OAKLAND MO
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: JOEL ANDREW BROYLES
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: MARRIED
6. (b) Name of husband or wife: MARTHA ELLEN KELSEY
6. (c) Age of husband or wife if alive: 69 years
7. Birth date of deceased: APRIL (Month) 18 (Day) 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
75	11	29	hr. min.

9. Birthplace: LACLEDE CO (City, town, or county) MO (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business:
FATHER 12. Name: THOS. BROYLES
13. Birthplace: (City, town, or county) O (State or foreign country)
MOTHER 14. Maiden name: DELLIE RHODES
15. Birthplace: (City, town, or county) O (State or foreign country)
16. (a) Informant: Mrs J. A. Broyles
(b) Address: OAKLAND MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 4 19 43 (Month) (Day) (Year)
(c) Place: burial or cremation: WHITSON CEM.
18. (a) Signature of funeral director: PALMER'S
(b) Address: LEBANON
19. (a) 4-27-43 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 17 year 1943 hour 5 minute P. M.
21. I hereby certify that I attended the deceased from Feb 6 1943 to April 10 1943; that I last saw him alive on April 10 1943; and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Leakage (Mitral insufficiency) of Rheumatic origin duration 1 yr

Due to:

Due to: 92 ft

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

Major findings:
Of operations:
Of autopsy:

Duration

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: A. L. Anthony D. (M. D. or other)
Address: Oakland Mo Date signed 4-20-43

(Licensed Embalmer's Statement on Reverse Side)

Received MAY 1943
Laclede County Health Un
File No. 4-43-64
Date Filed MAY 11 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 D A Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.