

V. S. No. 2  
00M-2-43  
5-17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15237**  
Registrar's No. **262**

**FILED MAY 1943**  
Registration District No. **3943**

Primary Registration District No. **6075**

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Mo. State Hospital No. 4  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SARAH ADA BROOKS

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced, widowed Divorced

6. (b) Name of husband or wife H. T. Brooks, Sr.

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

7. Birth date of deceased January 19 About 1865  
(Month) (Day) (Year)

8. AGE: Years About 78 Months Days If less than one day  
hr. min.

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

10. Usual occupation House Work

11. Industry or business

MOTHER FATHER

12. Name Mangrum

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

14. Maiden name Unknown

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 4-19-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Standfield Cem.

18. (a) Signature of funeral director W.H. [Signature]

(b) Address Pector, Ark.

19. (a) April 29-1943 (b) Byrdie [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin

(c) City or town Holcomb  
(If outside city or town limits, write "RURAL")

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17  
year 1943 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from 3-30-43  
to April 17, 1943,  
that I last saw her alive on April 16 P.M., 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death chronic valvular heart disease

Duration unknown

Due to Arteriosclerosis

Due to Inflammation of old age

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations [Signature]

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?  
Holcomb, Mo.

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

23. Signature Lillian Arendale (M. D. or other)

Address State Hospital #1 Date signed 4-17-43

RECEIVED

District Health Officer No. 4

District File Number 543-2122

Date Filed 5-5-43

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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 W. H. Tully  
Licensed-Embalmer No. 264 Ark  
P. O. Address Reactor, Ark

**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.**