

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37583

State File No.

FILED DEC 29 1943

Registration District No.

Primary Registration District No. 3005

Registrar's No. 67

1. PLACE OF DEATH:

(a) County. BATES.
(b) City or town. BUTLER.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Butler Memorial Hospital. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days.
(Specify whether
In this community 22 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Cass. 19
(c) City or town Rural, (Coldwater Twp.) 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4 1/2 Miles n/e Drexel, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A. 1 year.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22,
year 1943 hour 4 minute 15 P. M.
21. I hereby certify that I attended the deceased from Nov. 17
1943, 19 to Nov. 22, 1943
that I last saw him alive on Nov. 22, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial
pneumonia
Due to Uremia and
Cerebral Hemorrhage.
Due to _____
Other conditions arteriosclerosis
(include pregnancy within 3 months of death)

Duration

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? _____
(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 _____
Signature E. E. Robinson (M. D. REGISTER)
Address Adrian, Mo. Date signed 11/24/43

3. (a) PRINT FULL NAME JOHN HERVEY BRADEN.

3. (b) If veteran, name war None. 3. (c) Social Security No. 494-16-3658

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cora K. Braden. 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased April, 13 1860.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 7 9 hr. min.

9. Birthplace Bates County 0 Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Grain & Feed Dealer.

11. Industry or business Elevator Operator. Rtd.

12. Name David Braden,

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

14. Maiden name Elizabeth M. Leech.

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

16. (a) Informant Mrs. Cora E. Braden.

(b) Address Drexel, Missouri.

17. (a) Burial (b) Date thereof 11-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sharon

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

(b) Address Drexel, Missouri.

19. (a) 11/24/43. (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

15010

DEC 9 1943

NOV 8 1945

RECEIVED

District Health Officer No. 7;

District File Number

11-43-1330

Date Filed

12-8-43

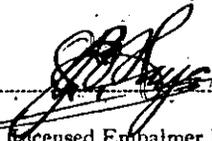
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me ~~XXXX~~

~~XXXXXX~~

working ~~XXXXXX~~

Signed



Licensed Embalmer No. 1950

P. O. Address Drexel, Missouri.

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1000
Registrar's No. _____

Registration District No. 27 Primary Registration District No. 2005

1. PLACE OF DEATH: Bates
(a) County Bates
(b) City or town Butler
(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 _____ (Specify whether
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 H. Brader
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 m
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 15
(Month) (Day) (Year)
8. AGE: Years 63 Months _____ Days _____ If less than one day _____ min.

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

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)

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)

20. DATE OF DEATH: Month April 20. 19 year 43 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ live on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death Bronchial Pneumonia, Chronic, hypertensive Hemipg & cerebral hemorrhage
Due to _____
Due to _____

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

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? _____ (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) (c) Means of injury _____

23. Signature E. E. Robinson (M. D., sealer)

Address Adrian, Mo. Date signed _____

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

SUPPLEMENTAL MEDICAL CERTIFICATION

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

37683