

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42638**

Registration District No. **10694**

Primary Registration District No. **55963031**

Registrar's No. **72**

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

1. PLACE OF DEATH:

(a) County **Jefferson**

(b) City or town **Desoto**

(c) Name of hospital or institution:
421 Flucon Rd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **70 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **JEFF 50**

(c) City or town **DE SOTO**
(If outside city or town limits, write "RURAL")

(d) Street No. **421 FLUCON RD**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **HATTIE BRUNK**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC** day **19**
year **1943** hour **3** minute **45 P.M.**

4. Sex **FEMALE**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **ROBT J. BRUNK**

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

7. Birth date of deceased **DEC 25 1873**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **12/9**, 19**43** to **12/19**, 19**43**
that I last saw her alive on **12/18**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **4hr**
Duration

8. AGE: Years **69** Months **11** Days **24** If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation **AT HOME**

Major findings: Of operations _____

11. Industry or business _____

12. Name **JAMES BRUNK**

13. Birthplace **ILL. I**
(City, town, or county) (State or foreign country)

14. Maiden name **MINNIE KEMPE**

15. Birthplace **DE SOTO MO**
(City, town, or county) (State or foreign country)

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **MRS Jodie Chappell**

(b) Address **Desoto Mo**

17. (a) **Burial** (b) Date thereof **DEC 22 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CHARTER Cem. PLATTIN MO**

18. (a) Signature of funeral director **J. B. Dickel**

(b) Address **Desoto Mo**

19. (a) **1-6-44** (b) **Fern Spencer**
(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 name of place)

23. Signature **John E. Gallet** (M. D. or other) _____

Address **Desoto Mo** Date signed **12/19/43**

387

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 *Donnell B. Dietrich*

Licensed Embalmer No. *4107*

P. O. Address *Idaho 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.