S. No. 2
1—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30422

Registration District No. 10 | Primary Registration District No. 3662 | Registrar's No. 136

1. PLACE OF DEATH:
(a) County Andrain
(b) City or town Mexico (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 526 W. Jackson (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Audrain
(c) City or town Mexico (If outside city or town limits, write "RURAL")
(d) Street No. 526 W. Jackson (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country 0

3. (a) PRINT FULL NAME THOMAS M. BROOKS
3. (b) If veteran, name war no
3. (c) Social Security No. 491-05-7750
4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret Brooks
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased 10 (Month) 5 (Day) 1885 (Year)
8. AGE: Years 58 Months 11 Days 5 If less than one day hr. min.
9. Birthplace Andrass (City, town, or county) Mo (State or foreign country)
10. Usual occupation Porter
11. Industry or business
12. FATHER Name Alfred Brooks
13. Birthplace Pike County (City, town, or county) O (State or foreign country)
14. MOTHER Maiden name Nora Thornton
15. Birthplace (City, town, or county) Ky (State or foreign country)
16. (a) Informant Mrs Mattie Smith
(b) Address 526 W. Jackson Mexico Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mexico Mo
18. (a) Signature of funeral director Stuart O. Parker
(b) Address Columbia Missouri
19. (a) 9/29/44 (Date received local registrar) (b) Margaret H Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 26 year 1944 hour 11 AM minute M.
21. I hereby certify that I attended the deceased from 9-5, 1944 to 9-26, 1944 that I last saw him alive on 9-26, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis — Duration
Due to
Due to
Other conditions Uremia
(Include 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 H. J. Hector (M. D. or other)
Address Mexico, Mo. Date signed 9-28-44

1074 (Licensed Embalmer's Statement on Reverse Side)

2-27-44

RECEIVED
District Health Officer No. 10
District File Number 10-44-16
Date Filed OCT 5 1944

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 Stuart R Parker

Licensed Embalmer No. 2900

P. O. Address Columbia 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.

3. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30422

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 136

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Mexico
(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 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 Thomas M. Brooks

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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 Oct (Month) 6 (Day) 8 (Year)

8. AGE: Years 58 Months 11 Days 5 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to

Due to

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

Urethreal Stricture

Major findings:
Of operations urinary extravasation

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 (M.D. or other)
Address Date signed

SUPPLEMENTARY

136a