No. 2
6-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3105

FILED FEB 3 1945

Registration District No. 2 8 0

Primary Registration District No. 4421

Registrar's No. 21

1. PLACE OF DEATH:
(a) County: Platte
(b) City or town: Parkville
(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 years, months or days)
In this community: 65 yr /

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Platte 83
(c) City or town: Parkville 3
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 0 (~~Yes or No~~) No
If yes, name country

3. (a) PRINT FULL NAME: Belle Broadhurst
3. (b) If veteran, name war:
3. (c) Social Security No. no

4. Sex: Female /
5. Color or race: White
6. (a) Single, widowed, married, divorced: W widow
6. (b) Name of husband or wife: Columbus Broadhurst
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Sept (Month) 24 (Day) 1854 (Year)

8. AGE: Years 90 Months 2 Days 21 If less than one day ..... hr. ..... min.

9. Birthplace: ESTILL ~~Missouri~~ (~~City, town~~, or county) KENTUCKY (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name: J. M. PRATHER
13. Birthplace: / KENTUCKY (City, town, or county) (State or ~~foreign country~~)
MOTHER
14. Maiden name: SMITH
15. Birthplace: / KENTUCKY (City, town, or county) (State or ~~foreign country~~)
16. (a) Informant: W. E. BROADHURST
(b) Address: PARKVILLE Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Parkville
18. (a) Signature of funeral director: Dalgard
(b) Address: Parkville Mo
19. (a) 1-24-45 (Date received local registrar) (b) Mrs Clay Biffee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 45 hour 6 minute A.M.
21. I hereby certify that I attended the deceased from Jan 12, 1945 to Jan 15, 1945 that I last saw h~~er~~ alive on Jan 15, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Old Age	
Due to	
Due to	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: J Underwood (M. D. ~~or other~~)
Address: Parkville Mo Date signed 1/23-45

1204 (Licensed Embalmer's Statement on Reverse Side)

DEC 3 1947

RECEIVED
District Health Officer No. Platte Co. Health Office
District File Number 2-45-21
Date Filed 2-1-45

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 F. S. Walton

Licensed Embalmer No. 2744

P. O. Address K. C. Mo

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

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

. 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. Feb

Registration District No. 280 Primary Registration District No. 4421 Registrar's No. 21

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Parkville
(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 Missouri (b) County Platte

(c) City or town Parkville
(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 Belle Broadhurst

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 24 (Day) 1854 (Year)

8. AGE: Years 90 Months 2 Days 21 If less than one day hr. min.

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

10. Usual occupation Had none

11. Industry or business

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

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

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (Month) (Day) (Year)

(c) Place: burial or cremation Parkville

18. (a) Signature of funeral director Noland

(b) Address Parkville Mo.

19. (a) 2-13-45 (Date received local registrar) (b) Mrs. Clay Giffin (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 15 year 1945 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

3105