

S. No. 2
M-3-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20675

FILED JUL 9 1945

State File No. _____

Registration District No. 164

Primary Registration District No. 2032

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Warrensburg Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 34 days
(Specify whether _____)

In this community 34 days
years, months or days Chinn

3. (a) PRINT FULL NAME Bette Brockman

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex F. 1

5. Color or race W

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

6. (b) Name of husband or wife Charles W. Brockman

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

7. Birth date of deceased 8-26-1861
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>8</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Dector Chinn

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

14. Maiden name Frauncelette

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

16. (a) Informant Mattie Brockman

(b) Address Maynew Mo

17. (a) 5-1945 (b) Date thereof 6 5 F
(Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director Walter A. ...

(b) Address Higginsville Mo

19. (a) June 4, 1945 (b) Deale M. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 579

(c) City or town Maynew
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3
year 1945 hour 3 minute 20 a.m.

21. I hereby certify that I attended the deceased from 4-30-45
_____, 19____, to 6-3, 1945

that I last saw her alive on 6-2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Duration 1 hr

Due to _____

Due to _____

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

Major findings:
Of operations 440

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) _____

(c) Means of injury _____

23. Signature Phil Cooper (M. D. or other) 29
Address Warrensburg Mo Date signed 6-4-45

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

10257

JUL 17 1945

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.....
Licensed Embalmer No. 539
P. O. Address.....

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.