

FILED JUB 19 1945

Registration District No. JUB 19 1945

Primary Registration District No. 3069

Registrar's No. 17143

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Mary's Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days) 5 Months

In this community 5 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Nebraska (b) County 999

(c) City or town Omaha
(If outside city or town limits, write "RURAL") 25

(d) Street No. 1310 Dodge Str.
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 22

If yes, name country _____

3. (a) PRINT FULL NAME Cornelius William Britt

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

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

6. (b) Name of husband or wife Elizabeth Nash Britt 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 29. 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>10</u>	<u>10</u>	hr. _____ min.

9. Birthplace Detroit Michigan 1
(City, town, or county) (State or foreign country)

10. Usual occupation Lawyer

11. Industry or business _____

12. Name Cornelius Britt

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Bridget Deagan

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Robert Britt

(b) Address 7042 Westmorland Ave.

17. (a) Removal (b) Date thereof 7/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Omaha, Neb.

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

(b) Address 2117 E. Grand Blvd.

19. (a) 7-11-1945 (b) C. E. M. Danawm
(Date received local registrar) (Registrar's signature) nsh

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1945 hour 3 minute P M.

21. I hereby certify that I attended the deceased from July 4 to July 9, 1945
that I last saw him alive on 7-9 and that death occurred on the date and hour stated above.

Immediate cause of death Ingestion Starvation
Parasitis 2 weeks

Due to Carcinoma of Tonsil 1 yr.

Due to and pharynx 45+

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Thomas M. Markin (M. D. assistant)
Address 634 No Grand Date signed 7/9/45

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

76
8
3

Rev. Prov. St. Martin
3943 Flora.

APR 19 1943

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 *Frank A. Brown*

Licensed Embalmer No. *3041*

P. O. Address *2117 E. Grand*

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.