

No. 2  
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-17-39  
X37623

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6272**  
Registrar's No. **80**

**FILED** FEB 25 1946  
Registration District No. **174**

Primary Registration District No. **3035**

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

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Lafayette  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rock St. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette 54  
(c) City or town Lafayette 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rock St 2  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)   
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME GARY W. BROOKS

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ma 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 19 1945  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	1	6	hr. min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Geo. E. Brooks

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

14. Maiden name Maria Mae Johnston

15. Birthplace Irma MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Geo. E. Brooks

(b) Address Lafayette, MO

17. (a) Burial (b) Date thereof 1-26-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lafayette, MO

18. (a) Signature of funeral director Frank E. Shupert

(b) Address Lafayette, MO

19. (a) Feb 1946 (b) Frank E. Shupert  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15  
year 1946 hour 6 minute AM M.

21. I hereby certify that I attended the deceased from as coroner, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia due to suffocation  
submer death!

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_

23. Signature W. Kappenberg (M. D. or other) MO  
Address St. Ignace, MO Date signed 1/29/46

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

156

(Licensed Embalmer's Statement on Reverse Side) Coroner Lafayette Co.

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date filed 2-21-46

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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

Signed Walter Embalmers Co. M. Keane

Licensed Embalmer No. 2983

P. O. Address Leungton 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. MeayRegistrar's No. 80Registration District No. 174Primary Registration District No. 3035

## 1. PLACE OF DEATH:

- (a) County Lafayette  
 (b) City or town Terre Haute  
 (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 days3. (a) PRINT  
FULL NAME Gary W. Brock

3. (b) If veteran,
- 
- name war \_\_\_\_\_

3. (c) Social Security
- 
- No. \_\_\_\_\_

4. Sex
- M
5. Color or race
- W
6. (a) Single, widowed, married,
- 
- divorced
- S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if
- 
- alive: \_\_\_\_\_

7. Birth date of deceased
- see
- 19
- 19
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days (Unless than one day)
- 
- \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_
- 
- (City, town, or county) (State or foreign country)

## 10. Usual occupation \_\_\_\_\_

## 11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_
- 
13. Birthplace: \_\_\_\_\_
- 
- (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_
- 
- (b) Address \_\_\_\_\_
- 
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation \_\_\_\_\_
- 
18. (a) Signature of funeral director \_\_\_\_\_
- 
- (b) Address \_\_\_\_\_
- 
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_
- 
- (Date received local registrar) (Registrar's signature)

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Jan
- 
- year
- 1946
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration  
\_\_\_\_\_Association due to  
enlarged thyroid gland. sudden.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: None **ADDITIONAL**  
Of operations \_\_\_\_\_ **SUPPLEMENTARY**  
**INFORMATION**  
Of autopsy no **REQUESTED**

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

## 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
- W. K. Higgins
- (M. D. or other)
- MD
- 
- Address
- Higgins Hill, MO
- Date signed
- 3/27/46

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

SUPPLEMENTARY

5255

10272