

Registration District No. 201

Primary Registration District No. 5738

Registrar's No.

1. PLACE OF DEATH:

(a) County Macou

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

(c) Name of hospital or institution:
L 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 3 yrs
years, months or days

3. (a) PRINT FULL NAME Carol Jean Brokaw

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

3. (c) Social Security No. 4

4. Sex F

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 Sept 20 1943
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>3</u>	<u>1</u>	<u>10</u>	hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Albert F. Brokaw

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

14. Maiden name Beatrice Gardner

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

16. (a) Informant Albert F. Brokaw

(b) Address Zablato Mo

17. (a) Rural
(Burial, cremation, or removal)

(b) Date thereof Nov 1 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Zablato

18. (a) Signature of funeral director D. Schuster

(b) Address Zablato Mo

19. (a) Nov 2 46
(Date received local registrar)

(b) Mrs. B. Trigg
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macou

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

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

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30,
year 1946 hour 2 minutes 30 P. M.

21. I hereby certify that I attended the deceased from Sept. 25, 1946, to Oct. 30, 1946
that I last saw him alive on Oct. 20, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Mononuclear Leucocytosis

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death).....

Major findings: Of operations..... 74A

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..... 0

23. Signature C. H. Puestling (M. D. or other)
Address Zablato Mo Date signed 11-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 10
District File Number 20-46-20-40
Date Filed NOV - 8 1946

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 *D.S. Christie*
Licensed Embalmer No. *1189*
P. O. Address *La Plata 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.