

Registration District No. **1** Primary Registration District No. **3000**

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

**1. PLACE OF DEATH:**  
 (a) County Plair  
 (b) City or town Green City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Green City Hospital & Clinic  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 hrs 15 min  
(Specify whether)  
 In this community same  
years, months or days  
(Dora G. Gid)

**3. (a) PRINT FULL NAME** Mrs. Victor D. Bratty  
**3. (b) If veteran,** name war ✓  
**3. (c) Social Security** No. ✓

**4. Sex** Female **5. Color or** race white  
**6. (a) Single, widowed, married,** divorced married  
**6. (b) Name of husband or wife** Victor **6. (c) Age of husband or wife if** alive 69 years  
Emmett  
**7. Birth date of deceased:** May 19 1878  
(Month) (Day) (Year)

**8. AGE:** Years 69 Months 1 Days 15 If less than one day  
 hr. min.

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

**10. Usual occupation** housewife

**11. Industry or business**  
**12. Name** Samuel James Hillbrite  
**13. Birthplace** Milawa, Mo.  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Marquet Rose  
**15. Birthplace** Milawa, Mo.  
(City, town, or county) (State or foreign country)

**16. (a) Informant** husband  
**(b) Address** Green City, Mo.

**17. (a) Burial** Burial **(b) Date thereof** 7-6-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Green City, Mo.

**18. (a) Signature of funeral director** Gloria E. Kenton  
**(b) Address** Green City, Mo.

**19. (a) 7-8-47** **(b) Kate Lambert**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Sullivan  
 (c) City or town Green City  
(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 July day 4  
 year 1947 hour 4 minute 20 P.M.  
**21. I hereby certify that I attended the deceased from** 4 July 1947 to 4 July 1947  
 that I last saw h. alive on 4 July 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac fibrillation Duration  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 126  
(Include pregnancy within 3 months of death)  
 Major findings: cholelithiasis  
 Of operations \_\_\_\_\_  
 Of autopsy none  
**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 0  
**23. Signature** E. R. Smith (M.D. or other)  
 Address Windsorville Date signed 7/6/47

RECEIVED  
District Health Officer No. 10  
District File Number 7-47-878  
JUL 14 1947  
Prob Files

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 Archie Ed Wade  
Licensed Embalmer No. 3037  
P. O. Address Green City, 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.