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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 26 1948

Registration District No. 11

Primary Registration District No. 3020

Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hrs. (Specify whether)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town _____ (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 _____

3. (a) PRINT FULL NAME Thomas Brookman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1948 hour 11 minute A M.

21. I hereby certify that I attended the deceased from March 11, 1948 to March 11, 1948
that I last saw him alive on March 11, 1948
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased March 13 1948
(Month) (Day) (Year)

Immediate cause of death Pulmonary Atelectasis

Duration 2 hrs.

8. AGE: Years _____ Months _____ Days _____ If less than one day 24 hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER, FATHER {

12. Name Thomas Brookman

13. Birthplace Mount Vernon Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Montgomery

15. Birthplace Terre Haute Indiana
(City, town, or county) (State or foreign country)

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

Major findings: 161A

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant St. Francis Hospital Reed

(b) Address Washington Mo

17. (a) Burial (b) Date thereof 3/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pacific Mo.

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? _____

18. (a) Signature of funeral director Pacific Mo.

(b) Address _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

19. (a) 3-15-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. _____)

Address PACIFIC Date signed 3/16/48

Date Filed MAR 25 1948

District File Number

District Health Officer No. 9,

RECEIVED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{Not} was embalmed by me, or by

, Registered Apprentice No.

working under my personal supervision.

Signed

Geo L Shields

Licensed Embalmer No. 300 F

P. O. Address Pacific 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.