

FILED MAY 3 1948

Registration District No. 12

Primary Registration District No. 3034

Registrar's No.

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Higginville
(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 days)

3. (a) PRINT FULL NAME Anna Dora Bright

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

4. Sex F / 5. Color or race W 6. (g) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ashton Bright 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Feb 22- 1897
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 24 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Johnny Andrew Brandt

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

14. Maiden name Mary Schorhorst

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

16. (a) Informant Anna Brandt
(b) Address Higginville Mo.

17. (a) Burial (b) Date thereof 4-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginville Mo.

18. (a) Signature of funeral director Robert Hoefler

(b) Address Higginville Mo.

19. (a) April 20-48 (b) Wayton H. Landrum
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Higginville
(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 April day 16th
year 1948 hour 9 minute 1 A.M.

21. I hereby certify that I attended the deceased from April 10th
1948 to Apr. 16, 1948;

that I last saw h. er alive on April 16, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Endocarditis

Influenza

Due to.....

Due to.....

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:

(c) 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 Leon Scheller (M. D. or other) D.O.

Address Higginville, Mo. Date signed 4-19-48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed.....5-1-48.....

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.....*Forrest A. Hooper*.....

Licensed Embalmer No. *43158*.....

P. O. Address.....*Higginville, T*.....

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 DEATH

State File No. May
Registrar's No. 27

Registration District No. 172

Primary Registration District No. 3034

1. PLACE OF DEATH

(a) County Luzerne
 (b) City or town Higginsville
 (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 _____ (Specify whether _____)
 years, months or days)

3. (a) PRINT FULL NAME Anna O. Bright

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased Feb. 22 (Month) (Day) (Year)

8. AGE: 56 Years Months Days (Less than one day) _____ hr. _____ min.

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

10. Usual occupation Housewife

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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 15-48 (b) Clayton H. Landrum
 (Date certified 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 April Day 16 Year 1948 Hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of 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?
 _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-13200