

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

FILED OCT 27 1949

Registration District No. 187

Primary Registration District No. 2038

Registrar's No. 228

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: McLarney Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Days  
(Specify whether  
In this community 30 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58  
(c) City or town Brookfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 703 Hansen Ave 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME THOMAS FRANCIS BRADY

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 Mar  
6. (b) Name of husband or wife Mary L. Brady 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June - 1 - 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 4 16 hr. min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business Shoe Repairer  
12. Name Michael P. Brady  
13. Birthplace D.A. D.K.I.  
(City, town, or county) (State or foreign country)  
14. Maiden name D.A.  
15. Birthplace D.A. D.R.U.  
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Brady  
(b) Address Brookfield Mo  
17. (a) Funeral (b) Date thereof 10-19-49  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St Michael Home  
18. (a) Signature of funeral director St Michael Home  
(b) Address Brookfield Mo  
19. (a) 10-19-49 (b) H. B. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

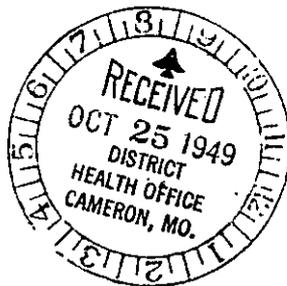
20. DATE OF DEATH: Month Oct day 17  
year 1949 hour \_\_\_\_\_ minute 5 A. M.  
21. I hereby certify that I attended the deceased from Oct 1946  
\_\_\_\_\_, 19\_\_\_\_, to 10/17, 1949;  
that I last saw him alive on 10/17, 1949;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration  
acute coronary occlusion 1 hr.  
Due to Generalized arteriosclerosis 53 yr  
Due to diabetes mellitus 10 years

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 260K  
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:  
(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 Reed W. Robinson (M. D. or other)  
Address Brookfield Date signed 10/19/49

5064 7-1-1954



**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..... *J. H. Blacklock*.....

Licensed Embalmer No. *2246*

P. O. Address..... *Brookfield 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.**