WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Barry

Township McDonald or Village or City (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 928 File No. 13433

Primary Registration District No. 50450 Registered No.

FULL NAME Johnathon Brooks

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: June (Month) 21 (Day), 1854 (Year)

AGE: 62 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or ......min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country): Tennessee

PARENTS

NAME OF FATHER: unknown

BIRTHPLACE OF FATHER (City or town, State or foreign country): unknown

MAIDEN NAME OF MOTHER: unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country): unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marde Carney

(ADDRESS) Purdy MO

Filed April 10 1916. S J Robertson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March (Month) 10 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 7, 1916, to Mar 10, 1916, that I last saw him alive on Mar 10, 1916 and that death occurred, on the date stated above, at 8:50 a.m. The CAUSE OF DEATH* was as follows:

108 Pneumonia

Ty Fever

(Duration) ......yrs. ......mos. ......ds.

Contributory (SECONDARY)

(Duration) ......yrs. ......mos. ......ds.

(Signed) S J Robertson M. D.

Mar 10, 1916 (Address) McDowell MO

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ......yrs. ......mos. ......ds. In the State ......yrs. ......mos. ......ds.

Where was disease contracted if not at place of death? ?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Sparks Cemetery

DATE OF BURIAL: Mar 12 1916

UNDERTAKER: P. E. Horine

ADDRESS: Cassville Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County ____________

Township ____________ or Village ____________ or City ____________ (NO. ________, ____________ St.; ________ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. ____________ File No. ____________

Primary Registration District No. ____________ Registered No. ____________

FULL NAME ____________

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH ____________ (Month) ______ (Day), 1______ (Year)

AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ______ hrs. or ______ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____________
(b) General nature of industry, business, or establishment in which employed (or employer) ____________

BIRTHPLACE (City or town, State or foreign country) ____________

PARENTS
- NAME OF FATHER ____________
- BIRTHPLACE OF FATHER (City or town, State or foreign country) ____________
- MAIDEN NAME OF MOTHER ____________
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) ____________

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____________

(ADDRESS) ____________

Filed ____________, 191______, ____________ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ____________ (Month) ______ (Day), 191______ (Year)

I HEREBY CERTIFY, that I attended deceased from ____________, 191______, to ____________, 191______,

that I last saw h______ alive on ____________, 191______,

and that death occurred, on the date stated above, at ______ m.

The CAUSE OF DEATH* was as follows:

____

____________ (Duration) ______ yrs. ______ mos. ______ ds.

Contributory (SECONDARY) ____________

____________ (Duration) ______ yrs. ______ mos. ______ ds.

(Signed) ____________ M. D.

____________, 191______ (Address) ____________

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.

Where was disease contracted if not at place of death? ____________

Former or usual residence ____________

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	____________, 191______
UNDERTAKER	ADDRESS