

REC'D APR 18 1938

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

Do not use this space.

1. PLACE OF DEATH
73 County Wentworth Registration District No. 608
6 Township Franklin Primary Registration District No. 6-807A
0 City Waller, Iowa St. _____ Ward _____

2. FULL NAME Bees Brather 635

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11606
File No. _____
Registered No. 12
St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unmarried

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1st May, 1859

7. AGE YEARS 78 MONTHS 8 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc. Hamburger

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

OCCUPATION

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Elie Roberts

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT Walter Brather (ADDRESS) Waller, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Concord Cem DATE Jan. 19 1938

19. UNDERTAKER J. B. Pope's Son (ADDRESS) Waller, Mo

FILED April 7, 1938 Ada Collins Registrar. 468

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 19, 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1937, to Jan 19, 1938
I last saw h. or alive on Jan 19, 1938 Death is said to have occurred on the date stated above, at 11 A. m.
The principal cause of death and related causes of importance were as follows:

fractured hip ✓
Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) Clardwell, M. D.
(Address) Waller, Mo

1800
18

MAIL
BIRTH
(2)
PRMAN
address
181

D.

1. IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

11606
Do not use this space.

PLACE OF DEATH
County Newton Registration District No. 608
Township Stella Primary Registration District No. 6807A Registered No. _____
City Stella (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

DECEASED FULL NAME Bell Bratten
Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY, AND YEAR)
AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 8 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FORMANT (ADDRESS)

17. CREMATION, OR REMOVAL DATE 19__

18. DIRECTOR (Address) 19__

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 19, 1935

22. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____. I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

fractured hip
Date of onset _____
Other contributory causes of importance: 1370 a

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide fall Date of injury 12-24-34
Where did injury occur? in home, hanging stairs
(Specify city or town, county and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fracture of left hip
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify C. Cardwell, M. D.
(Signed) Stella
(Address) _____

SUPPLEMENTARY

