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.

39 53 6

Filed AUG 14 1939

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

3 1

25603
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE Registration District No. 315
(b) Township Primary Registration District No. 2001 Registered No. 540
(c) or City SPRINGFIELD (d) Street No. 1125 S. BOULEVARD, St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 623 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SARAH JOSEPHINE BRACKETT
(a) Residence, No. 2130 PROSPECT St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female | 4. COLOR OR RACE: White | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3 - 1859

7. AGE: Years 80 | Months 1 | Days 1 | If LESS than 1 day, ...hrs. or ....min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. D 1 9

FATHER
13. NAME Joseph Lester
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Bland Brackett Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Comfort DATE July 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Kingston & Co. Springfield, Mo.

20. FILED July 5 1939 Chas A. Geoghegan Local Registrar 290

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1939, to July 4, 1939
I last saw h-e alive on July 3, 1939 Death is said to have occurred on the date stated above, at 7:00 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	July 4

Other contributory causes of importance:
Fracture Left Femur, Arteriosclerosis

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury June 1, 1939
Where did injury occur? At home
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
In Home
Manner of injury Fell on floor at home
Nature of injury Fracture Left Femur

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) W. A. DeGeer, M. D.
(Address) Springfield Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Warren D. Doblett

Licensed Embalmer No. 4005

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X