

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

16207

Registration District No. 11

Primary Registration District No. 4024

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Cassville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community life years, months or days

3. (a) PRINT FULL NAME Hugh S. Brixey

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 M
6. (b) Name of husband or wife Norma Brixey 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased July 7, 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 29 If less than one day hr. _____ min. _____

9. Birthplace Barry Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business _____

12. Name General M. Brixey
13. Birthplace Barry Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Montgomery
15. Birthplace Barry Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Norma Brixey

(b) Address Cassville, Mo.

17. (a) burial (b) Date thereof 5/7/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Exeter Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Cassville, Mo.

19. (a) May 11-1945 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County BARRY
(c) City or town CASSVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1945 hour 3 minute 5 A M.

21. I hereby certify that I attended the deceased from Aug. 12 1931, to May 6 1945
that I last saw him alive on May 6 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia 2 weeks. Duration

Due to Rheumatoid Arthritis 4 years

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:

(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 [Signature] (M. D. or other)
Address Cassville, Mo. Date signed 5/9/45

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

RECEIVED
District Health Officer No. 6,
District File Number 645-691
Date Filed JUN 8 1945

SEP 22 1947

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.....

Licensed Embalmer No. 3453

P. O. Address. Cassville, 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.