

FEB 20 1928

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

Do not use this space. 452

1. PLACE OF DEATH

County Cass Registration District No. 156  
Township Peculiar Primary Registration District No. 5220  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 6

2. FULL NAME Robert A. Brown

(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 31 yrs. — mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Agnes Brown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 3-1844

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
83 1 17

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Cass Co. Missouri  
(STATE OR COUNTRY)

10. NAME OF FATHER Robert A. Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Elizabeth Galloway

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Illinois

14. INFORMANT R. B. Brown  
(Address) Harrisonville, Mo.

15. FILED 1/21 1928 A. Shroy REGISTRAR  
OF Mary

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1928, to Jan 20, 1928, and that I last saw him alive on Jan 20, 1928, and that death occurred, on the date stated above, at 2:00 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) 74  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Scott Harrison  
(Signed) \_\_\_\_\_ M. D.  
1/20, 1928 (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brown Cemetery DATE OF BURIAL Jan 22 1928

20. UNDERTAKER Rumrumburg Bros Harrisonville Mo  
ADDRESS \_\_\_\_\_

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state how long deceased was ill. Do not use this space.

