

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

Do not use this space.

20588

**1. PLACE OF DEATH**

23122 *Andraiss*  
*Salt River*  
City *Mexico Mo.* (No. ....) (St. ....) (Ward ....)

Registration District No. *26*  
Primary Registration District No. *3002*

File No. ....  
Registered No. *77*

**2. FULL NAME**

*Mrs Isabelle Brown*

(a) Residence No. *321 W. Promenade* St. .... Ward. ....  
(Usual place of abode)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John Brown*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 4 1857*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>71</i>		<i>10</i>	<i>1</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) *H. W.*  
(STATE OR COUNTRY)

10. NAME OF FATHER *D. N. I.*

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

12. MAIDEN NAME OF MOTHER *D. N. I.*

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

14. INFORMANT *Mrs Bethel*  
(Address) *Mexico Mo.*

15. *June 5th 1929* *Erna S Milligan*  
FILED REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 5 1929*

17. I HEREBY CERTIFY, That I attended deceased from *June 1st* 1929, to *June 5* 1929 that I last saw her alive on *June 5* 1929, and that death occurred, on the date stated above, *11:40* a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Pneumonia Labor*  
*severely*  
CONTRIBUTORY (SECONDARY) *severely*  
(duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF .....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *R. S. Williams* M. D.  
, 19 (Address) *Mexico Mo*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Slater Mo* DATE OF BURIAL *19*

20. UNDERTAKER *Mo preeters Bros* ADDRESS *Mexico Mo*



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Audrain

Registration District No. 26

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 3082

Registered No. 77

City Mexico (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mrs Isabelle 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 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

F

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Wid

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_

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

(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

PARENTS

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**14.**

INFORMANT \_\_\_\_\_

(Address)

**15.**

FILE June 14 1929

Irma Milligan  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

June 5 1929

**17.**

I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_

19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, 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.

**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?

(Signed) \_\_\_\_\_, M. D.

, 19\_\_\_\_ (Address)

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

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

DATE OF BURIAL

Drove of Burial not stated 19\_\_\_\_

**20. UNDERTAKER**

Undertaker said he did not know

ADDRESS

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 OCCUPATIONS should state CAUSE OF DEATH. If OCCUPATION is very important. FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW REGISTRARS 5.

SUPPLEMENTARY

5-20588