

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

Do not use this space.

11886

1. PLACE OF DEATH

County Callaway
Township
City Fulton (No. _____)

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 83
St. _____ Ward

2. FULL NAME Ernest Brown

(a) Residence. No. State Hospital 16 Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) OK
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
32

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(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) _____

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 State Hospital (Address) Fulton

15. Apr 15 1930 R. N. Crews REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14 1930

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 14, 1930 that I last saw _____ alive on April 14, 1930, and that death occurred, on the date stated above, at 10:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral hemorrhage
82
85
_____ (duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (SECONDARY) Epilepsy
_____ (duration) 9 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) D. L. Stinson, M. D.

4-14-1930 (Address) State Hospital Fulton

*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 South Side Cemetery DATE OF BURIAL Apr 15 1930

20. UNDERTAKER Old Bell ADDRESS Fulton, Mo

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.

23 1930

