

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

Do not use this space.

17208

85

1. PLACE OF DEATH
 11 County Buchanan Registration District No. 1001
 5 Township St. Joseph Primary Registration District No. 1001
 9 City St. Joseph (No. Missouri, Methodist Hospt.) St. Ward

2. FULL NAME Clifford D. Brown Jr.
121 Ohio St.

(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. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 17, 1931

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>4</u>	<u>7</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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) St. Joseph Missouri

13. NAME Clifford D. Brown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph Missouri

15. MAIDEN NAME Faye Kunkle

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Kansas

17. INFORMANT (ADDRESS) Clifford D. Brown 121 Ohio St. St. Joseph Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Auburn Cem DATE May 25, 1931

19. UNDERTAKER (ADDRESS) Fred D. Clark 5025 King Hill Av

20. FILED 5-25 1931 John R. Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1931

22. I HEREBY CERTIFY, That I attended deceased from 5/24, 1931, to 5/24, 1931. I last saw him alive on 5/24, 1931. Death is said to have occurred on the date stated above, at 6 p. m.

The principal cause of death and related causes of importance were as follows:

180 cc. Fracture of Skull + laceration of brain

Date of onset 3/24/31

Other contributory causes of importance: Accidental fall

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury 3/24, 1931

Where did injury occur? St. Joseph, Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury Fall at St. Joseph Fall Mills

Nature of injury Fracture Skull

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) H. S. Brown, M. D.
 (Address) St. Joseph Mo

U.S.A.

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**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 St. Joseph Registration District No. 85 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 354
 City St. Joseph No. _____ St. _____ Ward _____

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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) _____

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. FILED 7-3 1931 John R. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 19 31

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of skull and laceration of brain

CONTRIBUTORY (SECONDARY) accidental fall from father's arms down stairs at the Lumber mills - not at home.

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 _____

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-17208