

MAR 2 1934

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

Do not use this space.

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1. PLACE OF DEATH *Stoddard*
County *Stoddard* Registration District No. *836*
Township *Exx* Primary Registration District No. *6100*
City (No. St. Ward)

2. FULL NAME *Rose Eliza Brown*
(a) Residence, No. St. Ward. (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.

File No. *16*
Registered No. *16*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Jesse Brown*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1879.*
7. AGE YEARS MONTHS DAYS *55* *unknown* *unknown* IF LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. */*
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) *Illinois*
13. NAME *George Green*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*
15. MAIDEN NAME *Liscia Green*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*
17. INFORMANT (ADDRESS) *Jesse H Brown*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Walton* DATE *2 10 34*
19. UNDERTAKER (ADDRESS)
20. FILED *3/9 134 J. P. Anderson Registrar.*

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-9-1934*
22. I HEREBY CERTIFY, That I attended deceased from *2-5-1934* to *2-9-1934*
I last saw him alive on *2-9-1934*. Death is said to have occurred on the date stated above, at *7:00* a.m.
The principal cause of death and related causes of importance were as follows:
Merria
11A B 1372 112
13 20
Other contributory causes of importance: *Asthma and Influenza*
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased?
If so, specify.
(Signed) *H. J. Hurtz*, M. D.
(Address) *Essex Mo.*

PHYSICIANS should state OCCASION is very important.

...ATION is very important

**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 Stoddard Registration District No. 836
 Township Clark Primary Registration District No. 6100
 City (No. _____) St. _____ Ward _____

2. FULL NAME Rose C. 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 16

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
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.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	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)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE _____ DATE _____ 19 _____				
19. UNDERTAKER <u>Home - home - made</u> (ADDRESS)				
20. FILED _____ 19 _____ <u>(Thompson)</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 279 1934
 22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) _____, M. D.
 (Address) _____

N. B.—Every item of information supplied for this purpose should be state "EXAMINED" if OCCUPATION is very important.
 CAUSE OF DEATH.
 T RECEIVE A FEE FOR
 ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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