

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

35361
 Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 8
 (b) Township Lincoln Primary Registration District No. 5 1/2 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Francis Brown

(a) Residence, No. Nodaway Mo. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas Jefferson Brown</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 3 1863</u>		
7. AGE YEARS <u>76</u>	MONTHS <u>7</u>	DAYS <u>3</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>at home</u>		
9. Industry or business in which work was done, as 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) <u>Holt County Mo.</u>		
13. NAME <u>Frank Rains</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Holt county Mo.</u>		
15. MAIDEN NAME <u>Emma E. Brant</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>un known un known</u>		
17. INFORMANT <u>Thomas Jefferson Brown</u> (ADDRESS) <u>Nodaway Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Highland</u> DATE <u>Oct 8 1939</u>		
19. FUNERAL DIRECTOR <u>E.C. Breit</u> (ADDRESS) <u>Savannah Mo.</u>		
20. FILED <u>@ Oct 7 1939</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 1939, to Oct 6, 1939
 I last saw h. e. p. alive on Oct 5th, 1939. Death is said to have occurred on the date stated above, at 7 A.M. m.
 The principal cause of death and related causes of importance were as follows:
Uremia
 Other contributory causes of importance:
Terminal Pneumonia
Hypostatic
 Name of operation _____ Date of operation _____
 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) Gilbert B. Kelley M. D.
 (Address) Savannah, Mo.

Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1112

RECEIVED

District Health Officer No. 117

District File Number 1139-1454

Date Filed NOV 7 1939

RECEIVED
DISTRICT HEALTH OFFICER
NOV 7 1939

STATEMENT BY LICENSED EMBALMER

I, E. C. Breit, Licensed Embalmer No. 2650

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. or by, Registered Apprentice No. working-under my personal supervision.

Signed

Licensed Embalmer No. 2650

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

35261
Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 8
(b) Township Lincoln Primary Registration District No. 5011 Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Francis Brown

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
76 7 3

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

9. Industry or business in which work was done, as 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6 1959

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19....., 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:

Tuberculosis Date of onset

Chronic nephritis

Terminal Pneumonia

Hypostatic

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) Robert B Kelley M. D.

(Address) Lawrence

SUPPLEMENTARY

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.

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

