

NOV 22 1939

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

35754

Do not use this space.

## 1. PLACE OF DEATH

(a) County Cass 2 Registration District No. 162  
(b) Township \_\_\_\_\_ Primary Registration District No. 5227 Registered No. \_\_\_\_\_  
(c) City Peculiar (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

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

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 - 1854

7. AGE YEARS 85 MONTHS — DAYS — If LESS than 1 day, .....hrs. or .....min.

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

13. NAME John Hall

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

15. MAIDEN NAME Rachel Sheppard

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

17. INFORMANT (ADDRESS) Sula M Bughly Peculiar, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Peculiar DATE 10/17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) RUNNENBURGER'S HARRISONVILLE, MO.

20. FILED 10/17 1939 Martin V. Robb Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 14 1939

22. I HEREBY CERTIFY, That I attended deceased from October 12 1939, to October 14 1939

I last saw her alive on October 14 1939. Death is said to have occurred on the date stated above, at 4 P. m.

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

Cerebral Hemorrhage - Date of onset 10/12/39

Other contributory causes of importance: Senility - arteriosclerosis ?

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

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) Martin V. Robb, M. D.  
\_\_\_\_\_ (Address) Peculiar, Mo

AS 1 (Licensed Embalmer's Statement on Reverse Side)

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

X. 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.

I X16825

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Ernest Rannenburg*  
Licensed Embalmer, No..... *3368*  
P. O. Address..... *Harrisonville Mo*

**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.)**

**If this body is not embalmed, above space should be left blank.**