

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39436

State File No. _____

Registration District No. 231

Primary Registration District No. 5315

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Crawford
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution ✓
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Osage Township
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Charley Thomas Brown 1050

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva Brown 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased July 23 1882
 (Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Leasburg, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Henry Brown

18. Birthplace Leasburg Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Miller

15. Birthplace Leasburg, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harold Brown
 (b) Address Cherryville Missouri

17. (a) Burial (b) Date thereof Nov. 18th 1938
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Martin Cem. Cherryville.

18. (a) Signature of funeral director Jack Holloway
 (b) Address Cuba, Missouri

19. (a) 12-10-39 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17th
 year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 1
 1938, to Nov 17 1938;
 that I last saw him alive on Nov 10 1938;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic
Valvular Disease of
Heart.
 Due to Ulcer of Stomach.

Duration

1 yr

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. B. Carter (M. D. or other) _____
 Address Stuville MO Date signed 11-17-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.

RECEIVED

District Health Officer No. 5,

District File No. 1239 507

Date Filed 122039

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.