

DEC 18 1939  
460

Registration District No. \_\_\_\_\_

Primary Registration District No. **5624-A**

Registrar's No. **62**

1. PLACE OF DEATH:

(a) County **Latahette Mo.**  
(b) City or town **on Highway 13 Rural Jones J.**  
(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

3. (a) PRINT FULL NAME **William Brown 650**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **493-14-9148**

4. Sex **M** 5. Color or race **Keloid** 6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **Anna May Brown** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **April 20 1907**  
(Month) (Day) (Year)

8. AGE: Years **32** Months **7** Days **4** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Johnson Co. Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Harvey Brown**  
13. Birthplace **Johnson Co. Mo.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Allie Grant Ruple**  
15. Birthplace **Way Co. Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs Allie Ruple**  
(b) Address \_\_\_\_\_

17. (a) **Burial** (b) Date thereof **Nov. 26 1939**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Mt Olive Cen. Johnson Co. Mo.**

18. (a) Signature of funeral director **W. S. Wilson**  
(b) Address **Warrensburg Mo. 64082**

19. (a) **Nov-30-39** (b) **Tiffany Webb**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**  
(c) City or town **Warrensburg**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **305 N. Main**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **24**  
year **1939** hour **3:20 AM** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Fractured skull  
Contusion of brain**

Due to **automobile accident**

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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) **Accident**  
(b) Date of occurrence **Nov. 23 1939**  
(c) Where did injury occur? **Latahette Mo.**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Public Highway**

While at work? **no** (Specify type of place) (e) Means of injury **outlet acting**

23. Signature **J. S. Cape** (M. D. or other)  
Address **Latahette Mo.** Date signed **11/24/39**

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.

210A.  
1/5

210A

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 1/5/39

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.....

Licensed Embalmer No.....

P. O. Address.....

*Donald L. Lupton*  
3053  
Warrersburg 186

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.

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 LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

40089 Do not use this space.

1. PLACE OF DEATH (a) County Lafayette (b) Township Paris (c) City (d) Street No. 460 (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. (g) Hospital or Institution name

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

PERSONAL AND STATISTICAL PARTICULARS 3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7. AGE YEARS 32 MONTHS 7 DAYS 4 If LESS than 1 day, hrs. or min. 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. FUNERAL DIRECTOR (ADDRESS) 20. FILED 19

MEDICAL CERTIFICATE OF DEATH 21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24 1939 22. I HEREBY CERTIFY, That I attended deceased from to, 19... Death is said to have occurred on the date stated above, at... The principal cause of death and related causes of importance were as follows: Fractured skull contusion of brain Date of onset Automobile accident Collision with fixed object 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 Nov 24 1939 Where did injury occur? Public highway Lafayette Mo (Specify city or town, county and State) Specify whether injury occurred in industry, in home or in public place. Public highway Manner of injury Automobile collision with fixed object Nature of injury Fracture of skull contusion of brain 24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) J. B. Cape M. D. (Address) Lexington Mo

SUPPLEMENT

