

Registration District No. 1-43

Primary Registration District No. 6164

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair <sup>2</sup>  
(b) City or town Rural Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Callins Mo. R.R.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 10 years  
years, months or days)

3. (a) PRINT FULL NAME MARGARET E. BROWN

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

4. Sex FE 5. Color or race W 6. (a) Single, widowed, married, divorced X

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased Dec 28, 1939  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>5</u> hr. <u>10</u> min.

9. Birthplace St. Clair Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business X

12. Name Hugh Jack Brown  
13. Birthplace Vallie Co. Wis.  
(City, town, or county) (State or foreign country)

14. Maiden name Dushia Lane  
15. Birthplace St. Clair Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hugh Jack Brown  
(b) Address Callins Mo.

17. (a) Burial (b) Date thereof Dec 29 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Mo.

18. (a) Signature of funeral director Hull  
(b) Address Osceola Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Clair  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Callins Mo. R.R.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 28 day \_\_\_\_\_  
year 1939 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec 28, 1939, to Dec 28, 1939;  
that I last saw her alive on Dec 28, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Blue Baby

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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 Dr. E. D. Brown (M.D. or other) DO

Address Callins Mo. Date signed 1-3-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

V. S. 4.  
50ML-5-17-39  
Rev. 5-17-39  
11-11-39

FILED  
JAN 11 1940  
DISTRICT HEALTH OFFICER

RECEIVED

District Health Officer No. 7,  
District File Number 1-40-29  
Date Filed 1-9-40

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**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.....

**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.**



