

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25673

State File No. _____

Registration District No. 1149

Primary Registration District No. 5697

Registrar's No. 7

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Paris (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 all of life years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME JOAB ROWE BROWN

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, divorced Widowed

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 6 1849
(Month) (Day) (Year)

8. AGE: Years 91 Months 5 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name John Brown
13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Not known
15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Francis Shaker
(b) Address Paris Mo

17. (a) Buried (b) Date thereof Aug 5 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Paris, Mo

18. (a) Signature of funeral director Wm. Brown
(b) Address Paris Mo

19. (a) 8-5-40 (b) Lee O. Carver
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3
year 1940 hour 5 minute 30 M.

21. I hereby certify that I attended the deceased from Aug 3, 1940, to Aug 3, 1940; that I last saw him alive on Aug 3, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarct
Due to Senility

Other conditions None
(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? 467 (Specify type of place)
(e) Means of injury _____

23. Signature Lee O. Carver (M. D. or other) _____
Address Paris Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 840-2464

Date Filed AUG. 07. 1940

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

Wm Morris Pogue....., Registered Apprentice No.
working under my personal supervision.

Signed

Wm Morris Pogue

Licensed Embalmer No.

13462

P. O. Address

Wheaton 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.