

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35457**
Registrar's No. **76**

Registration District No. **378** Primary Registration District No. **5532**

1. PLACE OF DEATH: **Howard**
(a) County **Howard**
(b) City or town **Rural S. Monticau**
(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 **2**
In this community **2**
years, months or days

3. (a) PRINT FULL NAME **Sally Ann Brown**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **March 12th 1867**
(Month) (Day) (Year)

8. AGE: Years **73** Months **7** Days **21** If less than one day hr. min.

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

10. Usual occupation **At home**

11. Industry or business **John Hern**

12. Name **Missouri**

13. Birthplace **Missouri** (City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Mead**

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

16. (a) Informant **Mrs Henry Warren** (b) Address **Fayette, Mo.**

17. (a) **Burial** (b) Date thereof **II-5th 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rocheport, Mo.**
(d) Signature of funeral director **Guy T. Halley**
(e) Address **Fayette, Mo.**

19. (a) **Nov 6, '40** (b) **Viola McCorble, dep.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Howard**
(c) City or town _____ (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **3** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Nov 2** 19**40** to **Nov 2** 19**40**, that I last saw him alive on **Nov 2** 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **Hypertension**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations **None** Of autopsy **None**

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? _____

(e) Signature **Mr J. Shan** (Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature **Mr J. Shan** (M. D. or other) **M.D.** Address **Fayette, Mo.** Date signed **11-3-40**

Duration **24 hrs.**
Physician **Unknown**
Underlines the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 8,
District File Number 11-14-40
Date Filed

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.