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1940  
FEDERAL BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36599

State File No. \_\_\_\_\_

Registration District No. 863

Primary Registration District No. 6137

Registrar's No. 29

1. PLACE OF DEATH:

(a) County: Texas

(b) City or town: Houston, Texas  
(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: 2  
(Specify whether \_\_\_\_\_)

In this community: \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME: FRANKLIN REO BROWN

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Ira Brown

6. (c) Age of husband or wife if alive: 67 years

7. Birth date of deceased: Oct 4 1871  
(Month) (Day) (Year)

8. AGE: Years: 69 Months: 0 Days: 19 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Texas Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

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

12. Name: Franklin Brown

13. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name: Sarah Thomas

15. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Ira Brown

(b) Address: Houston, Mo.

17. (a) Burial (b) Date thereof: 10/27/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Houston, Mo.

18. (a) Signature of funeral director: Gaylor D. Wallis

(b) Address: Houston, Mo.

19. (a) Oct 26 1940 (b) Mabel Shackell  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Texas

(c) City or town: Houston, Mo.  
(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: Oct day: 23 year: 1940 hour: 2 minute: 30 P.M.

21. I hereby certify that I attended the deceased from Aug. 28, 1939, to Oct 23, 1940, that I last saw him alive on Oct. 23, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: CORONARY OCCLUSION

Due to: CHRONIC ARTHRITIS DEFORMANS

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

Other conditions: SENILITY  
(Include pregnancy within 3 months of death)

Major findings: 94%  
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): \_\_\_\_\_

(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? All

While at work? \_\_\_\_\_ (Specify type of place)

23. Signature: G. M. Dillman (M. D. or other) M.D.

Address: HOUSTON, MO. Date signed: 10-24-40

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

RECEIVED

District Health Officer No. 5,

District File Number 11901122

Date Filed \_\_\_\_\_

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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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.