

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

Do not use this space.

44132

1. PLACE OF DEATH  
County Texas Registration District No. 568  
Township Sherrill 2 Primary Registration District No. 6149 File No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ Registered No. 40

2. FULL NAME Miss Mary Pruscilla Brown  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not married

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 5, 1877

7. AGE YEARS - MONTHS DAYS If LESS than 1 day, hrs. or min.  
63 1 25

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) Dec. 1940 11. Total time (years) spent in this occupation 45

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Beulah Mo.

FATHER  
13. NAME J. W. Brown  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER  
15. MAIDEN NAME Mary Dyer  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Albert R. Lemp  
620 S. Lincoln Walnut Hill

18. BURIAL, CREMATION, OR REMOVAL PLACE Fitcherson Denver 1-1-41

19. UNDERTAKER (ADDRESS) Smith & Ferguson  
Springfield Mo

20. FILED 12/31 1940 J. H. Hagedorn Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 30 40

22. I HEREBY CERTIFY, That I attended deceased from Dec 25 1940 to Dec 30, 1940  
I last saw her alive on Dec 30 1940 Death is said to have occurred on the date stated above, at 6:30 a.m.  
The principal cause of death and related causes of importance were as follows:  
Apoplexy  
Date of onset: \_\_\_\_\_

Other contributory causes of importance: 52%

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 \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. H. Hagedorn M. D.  
(Address) 116 E. 12th St. Springfield Mo

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

RECEIVED

District Health Officer No 5,

District File Number

14194

Date Filed

2B  
21-40  
X22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 44132

Registration District No. 868

Primary Registration District No. 6149

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Sherrell T.O.  
(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 Miss Mary Drussilla Brown

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 63 Months 1 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2/20/40 (b) [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas  
(c) City or town rural - Sherrell T.O.  
(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 Dec day 30 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

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 H. L. Reed (M. D. or other)

Address Licking, Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

