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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

2054<sup>+</sup>

State File No.                     

FILED FEB 14 1941  
125

Primary Registration District No. 3009

Registrar's No. 4

16  
1  
4

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

1. PLACE OF DEATH:

(a) County Cape, Co.

(b) City or town Cape Girardeau, Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State                      (b) County 79

(c) City or town Perryville Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A.                      years.

3. (a) PRINT FULL NAME Ruth J. 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 Single

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

7. Birth date of deceased Nov. 27 1926  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

14 1 8                      hr.                      min.

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

10. Usual occupation                     

11. Industry or business                     

MOTHER FATHER { 12. Name Raymond Brown

13. Birthplace Perry, Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Helen Zoellner

15. Birthplace Perry, Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Raymond Brown

(b) Address Perryville Mo

17. (a) Bural (b) Date thereof Jan 7 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Young & Sons

(b) Address Perryville, Mo

19. (a) 1-5-41 (b) J. M. Thompson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 4  
year 41 hour 4 minute 50 P.M.

21. I hereby certify that I attended the deceased from 12-28, 1940, to 1-4, 1941  
that I last saw her alive on 1-4, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Fr. Skull

Due to Haroldoche Bee.

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) Accident

(b) Date of occurrence Perryville Mo

(c) Where did injury occur? Perryville Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place  
(Specify type of place)

While at work?                      (b) Means of injury                     

23. Signature G. T. Smith (M. D. or other)                     

Address Cape Girardeau Date signed 1/5/41

Duration                     

PHYSICIAN                     

Underline the cause to which death should be charged statistically.

170c  
98

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

*Wallace Young*

Licensed Embalmer No.....

*4027*

P. O. Address.....

*Perryville, Md.*

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, fact should be so stated above.

H.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 2054

Registration District No. 125

Primary Registration District No. 2009

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

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(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

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

8. AGE: Years Months Days If less than one day  
14 1 8 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)  
(Burial, cremation, or removal)

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

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(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 1 day 4  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Skull  
automobile acc  
auto collision  
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) acc  
(b) Date of occurrence 12-28-40  
(c) Where did injury occur? Ferryville (City or town) (County) (State) MO  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on Hwy (Specify type of place) Auto (e) Means of injury Auto

23. Signature A. L. Luert (M. D. or other) \_\_\_\_\_  
Address Cape Gir Date Signed \_\_\_\_\_

SUPPLEMENTARY

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

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

