

No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25395**

Registration District No. **441**

Primary Registration District No. **3701A**

Registrar's No. **42**

1. PLACE OF DEATH:

(a) County **Knox**
(b) City or town **Edina (Rural) Lyon TIA MO**
(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 **Life** / (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Knox**
(c) City or town **Edina (Rural)**
(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? **0** years.

3. (a) PRINT FULL NAME **Walter Raleigh Brown**

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

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

6. (b) Name of husband or wife **Purn Martin** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **3 18 82**
(Month) (Day) (Year)

8. AGE: Years : Months Days If less than one day
59 4 7 hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **William B. Brown**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Marinda E. Prosser**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wood House**
(b) Address **Knox City MO**

17. (a) **Burial** (b) Date thereof **7 27 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Harmony**

18. (a) Signature of funeral director **Kath Hudson**

(b) Address **Edina Missouri**

19. (a) **July 26 1941** (b) **Mrs. C.M. Smith**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **25**
year **1941** hour **11** minute **44** a.m.

21. I hereby certify that I attended the deceased from **July 24**
1941 to **July 25** 1941;
that I last saw him alive on **July 25** 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis**

Due to **Strangulated Hernia**

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 **PO**

23. Signature **C.C. Gibson** (M. D. or other) **PO**

Address **Edina MO** Date signed **7-27-41**

0520

Duration

1 Day

24 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

172A

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

002

RECEIVED

District Health-Officer No: 10

District File Number 8-41-1426

Date Filed AUG 6 1941

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Minn

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.