No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25447

Registration District No. 470 Primary Registration District No. 5633 Registrar's No. 117

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt. Vernon, R.R. #1 Twp (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 75 years! years, months or days)

2. USUAL RESIDENCE OF DECEASED: 055

(a) State Mo (b) County Lawrence

(c) City or town Mt. Vernon, Rural (If outside city or town limits, write "RURAL.")

(d) Street No. 3 3/4 miles N.E. of Mt. V. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Charles W. Brown

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race white

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 20 (Day) 1861 (Year)

8. AGE: Years 79 Months 8 Days 29 If less than one day hr. min.

9. Birthplace unk (City, town, or county) Ill (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Wm Brown
13. Birthplace unk (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Maynard Walker

(b) Address Mt. Vernon Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Summit Cemetery

18. (a) Signature of funeral director H. D. Fassett

(b) Address Mt. Vernon Mo

19. (a) 7-21-1941 (Date received local registrar) (b) 42 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 41 hour 5:00 minute P.M. M.

21. I hereby certify that I attended the deceased from April 5 1941 to July 19 1941; that I last saw him alive on July 25 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Apoplexy and Hypertension	60 days
Due to	
Due to 131 lb	
Other conditions Chronic nephritis (Include pregnancy within 3 months of death)	5 years+

Major findings:
Of operations —
Of autopsy no

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature P A Holmer (M. D. ~~or other~~) 0

Address Mt Vernon Mo Date signed 7-21-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 841-1340
Date Filed AUG 7 1941
AUG 7 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 Max. L. Fassett, Registered Apprentice No. 269 working under my personal supervision.

Signed H. D. Fassett

Licensed Embalmer No. 2201

P. O. Address Mt. Vernon

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.

S. No. 2B
M—8-21-41
1 X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 95447

Registration District No. 470 Primary Registration District No. 5633 Registrar's No. 117

1. PLACE OF DEATH

(a) County: Lawrence

(b) City or town: Mt Vernon RR #1
(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 years, months or days)

In this community: 75 yrs

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Charles W. 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: 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 | Months | Days | 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-21-1941 (Date received local registrar) (b) P A Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day year 41 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 — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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)

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

While at work? (c) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-25447