

FILED AUG 14 1941

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

Do not use this space.

25600

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
Township Mason Primary Registration District No. 3029 Registered No. 202
City Hempstead (No. 1618 Wardlow) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1618 Wardlow St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
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OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Fabron
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) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 13. NAME Peter Brown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Sarah Brown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Homer Brown
(ADDRESS) 1618 Wardlow

18. BURIAL, CREMATION, OR REMOVAL
PLACE Baphat DATE 6-21 1941

19. UNDERTAKER Geo E Roberts
(ADDRESS) Hempstead Mo

20. FILED July 1, 1941 19 458 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-18 1941

22. I HEREBY CERTIFY That I attended deceased from June 12 1941, to June 15 1941.
I last saw him alive on June 15 1941. Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

Cardiac embolism
septicemia ✓ 1318

Other contributory causes of importance:

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 _____, 1941

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) A. W. Fox M. D.
(Address) Hempstead 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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25600
Registrar's No. 202

Registration District No. 547

Primary Registration District No. 3029

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

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Marion
(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 John Brown
(b) If veteran, name war.....
(c) Social Security No.....

4. Sex M 5. Color or race B
6. (a) Single, widowed, married, divorced S
(b) Name of husband or wife.....
(c) Age of husband or wife if alive..... years
7. Birth date of deceased January
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 1
(If less than one day min)

9. Birthplace.....
(City, town, or county) (State or foreign country)
10. Usual occupation.....
11. Industry or business.....
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.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....
19. (a) Sept 18, 1991 (b) E. M. Rucke
(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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

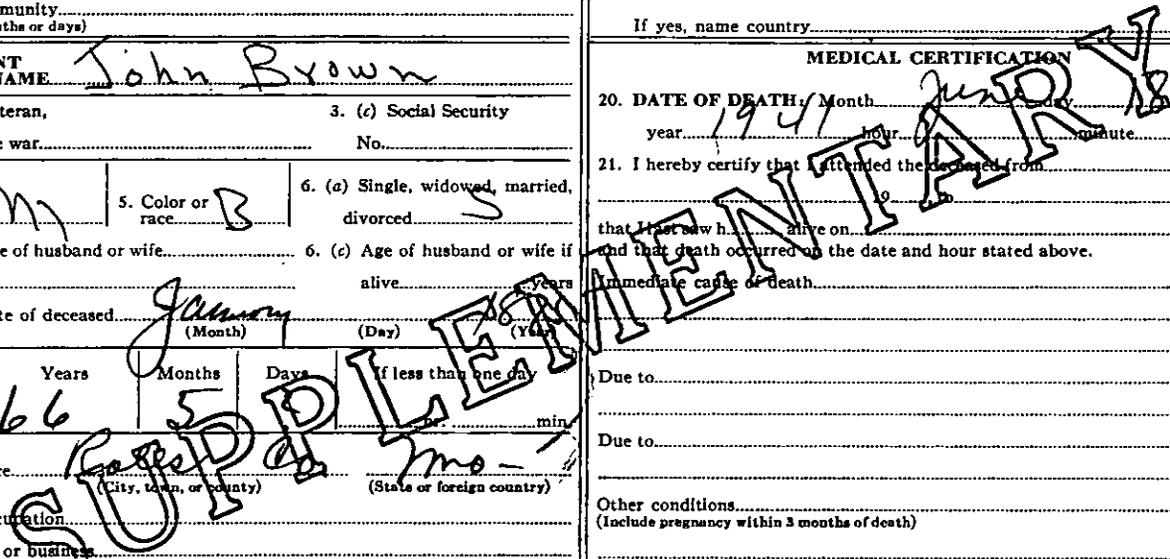
20. DATE OF DEATH: Month July Day 18
Year 1991 Hour..... Minute..... M.
21. I hereby certify that I attended the deceased from.....
to....., 19.....
that I last saw him alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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?
While at work?..... (Specify type of place)
(c) Means of injury.....
23. Signature..... (M. D. or other).....
Address..... Date signed.....



S-25600