. No. 2
—1-4-41
5-17-39
I X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 22 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36419

Registration District No. 901 Primary Registration District No. 6210 Registrar's No. 97

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Rogersville Rural
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Webster
(c) City or town Rogersville Rural
(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 EFFIE MAY 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 Wid
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 about 40 Months Days If less than one day hr. min.
9. Birthplace not known (City, town, or county) (State or foreign country)
10. Usual occupation House Keeper
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 (Burial, cremation, or removal) (b) Date thereof 11-7-41 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director Kelley Funeral
(b) Address Rogersville, Mo
19. (a) 11-6-41 (Date received local registrar) (b) J. C. Barnes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 5 year 1941 hour 11:00 minute A. 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 — Duration
Pulmonary Hemorrhage
Due to
Pulmonary tuberculosis
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)
(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 O. G. Beers Coroner (M. D. ~~Coroner~~)
Address Seymour Mo Date signed 11-6-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number NOV-141-1743
Date Filed NOV 17 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 T. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Seymour, Mo.

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.