

DEC 12 1941
Registration District No. **678**

Primary Registration District No. **5916**

Registrar's No. **21**

1. PLACE OF DEATH:
(a) County **Pike Lewis Sherman Brown**
(b) City or town **Frankford**
(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 **42 Years**
In this community **42 Years**
years, months or days

3. (a) PRINT FULL NAME **Lewis Sherman Brown**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Lillie Childs** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 10 1861**
(Month) (Day) (Year)

8. AGE: Years **80** Months **12** Days _____ If less than one day _____ hr. _____ min.
9. Birthplace **St. Charles County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**
11. Industry or business _____
12. Name **Antotne Brown**
13. Birthplace **Baden, Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Angeline Davedson**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Claud Brown**
(b) Address **Frankford Missouri**
17. (a) **Burial** (b) Date thereof **Oct 24 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Frankford Missouri**
18. (a) Signature of funeral director **Field & Son**
(b) Address **Frankford Missouri**
19. (a) **Nov-17-41** (b) **Mathie Ursell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Pike**
(c) City or town **Frankford 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.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **22**
year **1941** hour **9** minute **30** A.M.
21. I hereby certify that I attended the deceased from **March 9, 1937** to **Oct. 22, 1941**
that I last saw him alive on **Oct. 22, 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral of mouth and throat**
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)
(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 _____
23. Signature **W. L. Spess** (M. D. or other) _____
Address **Frankford Mo** Date signed _____

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 12-41-2168

Date Filed DEC 10 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

Jane Fields Negro

Licensed Embalmer No. 4093

P. O. Address Frankford, Pa.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39125

Registration District No. 548

Primary Registration District No. 5916

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Osage
- (b) City or town Frankford
(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 Louis S. Braun

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 _____

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

7. Birth date of deceased Sept. 10 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____
(If less than one day Hr. _____ min. _____)

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

10. Usual occupation _____

11. Industry of 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) _____ (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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him _____, _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction Duration _____

Due to longer left groin from base of center

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature D. W. [unclear] (M. D. or other) _____

Address Frankford, Mo. Date signed 11/9/42

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

SUPPLEMENTARY 2

S-39125