

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11441

FILED Mar 18 1942 55
Registration District No. 287

Primary Registration District No. 41-68 100-62

Registrar's No. 21

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town 9 mi S-E of Bidson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
In this community 2 months
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County N. Madrid
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. 9 mi S-E of Bidson
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Wm. H. Brown
(b) If veteran, no name war none
(c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 1st
year 1942 hour 4-1 minute 10A M.

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Agnes Brown
6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased Dec 10th 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-7, 1942, to 2-14, 1942, that I last saw him alive on 2-14, 1942, and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 2 Days 18
If less than one day hr. min.

Immediate cause of death Pulmonary Phthisis Duration 6 mo

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

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 13 1/2

10. Usual occupation Farmer + Timber Worker

Major findings: Of operations _____
Of autopsy _____

11. Industry or business Farm Laborer

12. Name unknown
13. Birthplace Ill
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature J. Monteith
(b) Address Rt 4, Paragould Ark.

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? _____

17. (a) Burial (b) Date thereof 3-2-1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paragould ark

18. (a) Signature of funeral director Randal L. Mitchell
(b) Address Paragould Ark.

19. (a) Mar. 1, 1942 (b) L. F. Brown
(Date received local registrar) (Registrar's signature)

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

23. Signature J. B. Stearns (M.D. or other) M.D.
Address Clarkston Mo Date signed 3-1-42

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

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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RECEIVED

District Health Office No. 2,

District File Number 342-421

Date Filed 3-13-42

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 11441

Registration District No. 284

Primary Registration District No. 4168

Registrar's No. 2

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town 9 mi. S.E. of Hixson
(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. 2 months years, months or days)

3. (a) PRINT FULL NAME Wm H. 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 w.

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 66 Months 2 Days 11 (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry of 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) _____ (b) Date thereof _____ (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 mar day _____ year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her 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)

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

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