

FILED AUG 12 1942

Registration District No. **469470**

Primary Registration District No. **2633**

Registrar's No. **31**

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30  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Lawrence**  
(b) City or town **Mt. Vernon**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **20 year** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lawrence**  
(c) City or town **Mt. Vernon**  
(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 **14**  
year **1942** hour **15** minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from **Feb 1941**  
19 \_\_\_\_\_ to **July 14** 19 **42**  
that I last saw her alive on **July 14** 19 **42**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocardial Failure**  
Due to **Cachexia**

Due to **Post-op. stricture + adhesions of stomach & hepatic system**  
Other conditions: **12 yr**  
(Include pregnancy within 3 months of death)

Major findings: **Adhesions & stricture of hepatic structures; demonstrable adhesions.**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Katherine Browning**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** / 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Lester** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased: **Jan 19 1899**  
(Month) (Day) (Year)

8. AGE: Years **43** Months **5** Days **25** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Verona Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **H. P. Grigg**

13. Birthplace **Newtonia Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Kate Hill**  
15. Birthplace **Minnesota**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Kate Grigg**

(b) Address **Royal Oak Hill**

17. (a) **Burial** (b) Date thereof **July 1942**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Spring River Cemetery**

18. (a) Signature of funeral director **H. D. Fassitt**

(b) Address **Mt. Vernon Mo**

19. (a) **July 14-42** (b) **away from**  
(Date received local registrar) (Registrar's signature)

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?  
White at work? \_\_\_\_\_ (Specify type of place)  
( ) Means of injury \_\_\_\_\_  
23. Signature **Dorothy Glover M.D.** (M. D. or other)  
Address **Mt. Vernon Mo** Date signed **7/21/42**

AUG 1 1942

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.....

*Eugene Wood*

Licensed Embalmer No.....

P. O. Address.....

*Marionville T*

**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.**