

ED MAR 11 1943

Registration District No. **38**

Primary Registration District No. **3006-520**

Registrar's No. **78**

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

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Columbia**
(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:
In this community **all of her life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **NANCY BROWN**

3. (b) If veteran, name war: _____ 8. (c) Social Security No. _____

4. Sex **F** 5. Color or race **colored** 6. (a) **Single**, widowed, married, divorced **1**

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

7. Birth date of deceased **Sept 21 1877**
(Month) (Day) (Year)

8. AGE: Years **66** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Boone Co MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business

MOTHER FATHER
12. Name **John Flynn**
13. Birthplace **Boone Co MO**
(City, town, or county) (State or foreign country)
14. Maiden name **Liza Flynn**
15. Birthplace **Boone Co MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Liza Brown**
(b) Address **N. F. D. # 1 Brown St.**

17. (a) **Burial** (b) Date thereof **3-1-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **mt. Maria Cem.**

18. (a) Signature of funeral director **P. L. T. T. T.**
(b) Address **608 Park St. Columbia**

19. (a) **3-1-43** (b) **E. A. H. Barton**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Boone**
(c) City or town **Columbia**
(If outside city or town limits, write "RURAL")
(d) Street No. **R. F. D. # 1 Brown St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **1** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2**, day **25**, year **43** hour **11** minute **15 A. M.**

21. I hereby certify that I attended the deceased from **24** 19 **42** to **2/25** 19 **43**
that I last saw her alive on **2/24/43** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
Apoplexy
Due to _____
Due to **Apoplexy**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **92 R**
Of autopsy _____

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 **H. R. Barton** (M. D. or other) **MA**
Address **508 Park** Date signed **3/1/43**

1250

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed A. C. Freeman

Licensed Embalmer No. 2837

P. O. Address 408 Park St. Columbus

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.