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5-17-43  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24339  
State File No. \_\_\_\_\_  
Registrar's No. 770

AUG 5 1943  
Registration District No. 42

Primary Registration District No. 1000

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

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: 2207 Sylvania St.  
(d) Length of stay: In hospital or institution 81 years  
In this community 81 years

3. (a) PRINT FULL NAME: Robert C. Brown  
3. (b) If veteran, name war: None  
3. (c) Social Security No.: None

4. Sex: Male  
5. Color or race: Black  
6. (a) Single, widowed, married, divorced: Married  
6. (b) Name of husband or wife: Mary E.  
6. (c) Age of husband or wife if alive: 79 years  
7. Birth date of deceased: February 13 1862

8. AGE: Years 81, Months 4, Days 27

9. Birthplace: St. Joseph Missouri

10. Usual occupation: Minister  
11. Industry or business: Methodist Church

MOTHER FATHER {  
12. Name: John Brown  
13. Birthplace: Louisville Kentucky  
14. Maiden name: Cecelia Craft  
15. Birthplace: Tennessee

16. (a) Informant: Mary E. Brown (Wife)  
(b) Address: 2207 Sylvania St., St. Joseph  
17. (a) Burial (b) Date thereof: 7/14/43  
(c) Place: burial or cremation: Ashland Cemetery

18. (a) Signature of funeral director: Lincoln Mortuary  
(b) Address: 107 W. Missouri Ave., City  
19. (a) 7-14-43 (b) Rose [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Buchanan  
(c) City or town: St. Joseph  
(d) Street No.: 2207 Sylvania St.  
(e) Citizen of foreign country? No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 10  
year 1943 hour 9 minute 00 A.M.  
21. I hereby certify that I attended the deceased from July 9, 1943 to July 10, 1943  
that I last saw him alive on July 9, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy  
Duration: 24 hrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: None made

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
23. Signature: [Signature] (M. D. or other) \_\_\_\_\_  
Address: 109 1/2 West Missouri Ave. Date signed: 7-18-43

**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, fact should be so stated above.**