

FILED OCT 20 1943

Registration District No. 109

Primary Registration District No. 5424

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Campbell Mo R.F.D. 2
(c) Name of hospital or institution: Home in no. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Campbell Mo R 2 Union
(If outside city or town limits, give "RURAL")
(d) Street No. Union Exp Route 2
(If rural, give location)
(e) Citizen of foreign country? no (or No)
If yes, name country.....

In this community.....
3. (a) PRINT FULL NAME Joseph Thomas 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 married
6. (b) Name of husband or wife Sarah Ann Brown 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased May 4th 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business.....

12. Name unknown

13. Birthplace USA (City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace USA (City, town, or county) (State or foreign country)

16. (a) Informant Roy E. Brown

(b) Address 27 Campbell R 2

17. (a) burial (b) Date thereof Oct 3 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Capon

18. (a) Signature of funeral director Clayd Russell

(b) Address Piggott Ark

(c) 10-16-1943 (b) Mrs. A.P. Oliver
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 30 day 1943
year..... hour..... minute 7:30 P.M.

21. I hereby certify that I attended the deceased from Sept 17 1943, to Sept 30 1943; that I last saw h. in alive on Sept 30 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
acute failure

Duration 2 yrs +

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 921

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 Wallace Selony (M. D. or other) md

Address Campbell Mo. Date signed 10/15/43

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

35
0
11
Burial
D
241
10/20/43

OCT 20 1943

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.....

Lloyd Russell

Licensed Embalmer No.....

509

P. O. Address.....

Piggott, Ark

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.