

FILED DEC 8 1943

Registration District No. _____

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(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 12 days years, months or days

3. (a) PRINT FULL NAME Angelina Brown

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

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

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

7. Birth date of deceased Nov 1st - 1861 (Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Douglas Co., Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jocce Strong

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

14. Maiden name unk

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

16. (a) Informant W. J. Brown

(b) Address West Plains Mo R.F.D.

17. (a) _____ (b) Date thereof 11-3-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Local

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 11-15-43 (b) J. H. Starnes (Date received local cert.) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1 year 1943 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct. 23, 1943, to Nov. 1, 1943; that I last saw her alive on Oct. 30, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Duration 7 days

Due to Fractured femur, right

and Acute Dysentery

Other conditions Smelly - \$34.00 del (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Fractured femur, 11/24/43

(b) Date of occurrence 11/23/43

(c) Where did injury occur? W. Plains Howell Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home on a farm

While at work? no (Specify type of place) (e) Means of injury Accident

23. Signature Act. J. H. Starnes (M. D. or other) M.D. Address West Plains, Mo. Date signed 11/11/43

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

MOTHER FATHER

RECEIVED

District Health Officer No 5,

District File Number 1243694

Date Filed 12. 7. 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 A. L. Roberts

Licensed Embalmer No. 3438

P. O. Address West Hill, M

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.