

FILED DEC 6 1943

Registration District No. **322**

Primary Registration District No. **4471**

Registrar's No. **3**

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

1. PLACE OF DEATH:
 (a) County **Saline**
 (b) City or town **Gilliam**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **none**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **no**
 In this community **69 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Saline**
 (c) City or town **Gilliam**
 (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 _____

3. (a) PRINT FULL NAME **Joseph Perthier Brown**
 3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov.** day **8th**
 year **1943** hour **11.00** minute _____ M.

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife **none**
 6. (c) Age of husband or wife if alive **no** years
 7. Birth date of deceased **Feb. 1857**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **November 4, 1943 to November 8, 1943**
 that I last saw him alive on **November 8, 1943**
 and that death occurred on the date and hour stated above.

8. AGE: Years **86** Months **8** Days **18**
 If less than one day _____ hr. _____ min.

Immediate cause of death **Cerebral Apoplexy**
 Duration **4 days**

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

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

10. Usual occupation **farmer**

Major findings:
 Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name **John P. Brown**
 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name **Catherine Corcoran**
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

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

16. (a) Informant **Ernie Brown**
 (b) Address **Gilliam, Mo.**
 17. (a) **burial** (b) Date thereof **11-10-43**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Gilliam, Mo.**
 18. (a) Signature of funeral director **Bill Roberts**
 (b) Address **later, Mo.**
 19. (a) **Nov 30-43** (b) **Miss John Giger**
 (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?
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature **M. C. [unclear]** (M. D. or other) _____
 Address **State, Mo.** Date signed **11/9/43**

RECEIVED

District Health Officer No. 81

District File Number 1

Date Filed 12-3-43

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. C. Hill*

Licensed Embalmer No. 3090

P. O. Address State, Mo.

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.