

S. No. 2
M-542
7-5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39266

State File No.

FILED DEC 6 1943

Registration District No. 322

Primary Registration District No. 30-776a

Registrar's No.

1. PLACE OF DEATH

(a) County Saline

(b) City or town Rural Miami
(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 all Her life
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Near Fairville Mo
(If rural, give location)

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

3. (a) PRINT FULL NAME Lillie Graves Brown

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20
year 1943 hour 1 min 20 P.M.

21. I hereby certify that I attended the deceased from 11-19-43, 19____ to _____, 19____;
that I last saw her E.R. alive on 11-19-43, 19____;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of hair White 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased June-1-1860
(Month) (Day) (Year)

Immediate cause of death Myocardial Failure

Due to Senility

Due to _____

Other conditions (Include pregnancy within 3 months of death) 9322

8. AGE: 83 years 5 months 19 days If less than one day _____ hr. _____ min.

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas C Graves

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

14. Maiden name Mary Callaghan Barnett

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

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? _____

16. (a) Informant Mrs George Fowler

(b) Address Marshall St # 2

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-23-43
(Month) (Day) (Year)

(c) Place: burial or cremation Rehoboth

18. (a) Signature of funeral director James K. Stager

(b) Address State St

19. (a) 11-24-43 (Date received local registrar) (b) Mrs John Gign (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury 2

23. Signature P. J. Warren (M. D. or other) DO

Address Marshall Mo Date signed 11/23/43

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

RECEIVED

District Health Officer No. 8

District File Number

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

Joe E. Jones

Licensed Embalmer No.

3158

P. O. Address

Slater Md

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.