S. No. 2
—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6554

State File No. .....

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 148

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital # 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs 0 mos 10 days (Specify whether In this community yes years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

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

(d) Street No. 1522 Edmond St (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Annie Payne Brown

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Robert Brown.

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

7. Birth date of deceased Aug (Month) 21 (Day) 1866 (Year)

8. AGE: Years 77 Months 5 Days 22 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired

11. Industry or business Telephone Exchg Operator.

FATHER
12. Name Robert Payne
13. Birthplace Howard Co Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucy E Basket
15. Birthplace Howard Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Robert Brown

(b) Address St Joseph

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2 (Month) 15 (Day) 44 (Year)

(c) Place: burial or cremation Nebraska City Nebr.

18. (a) Signature of funeral director Herman W. Sidenfuden

(b) Address 1802 Union St. St. Joseph Mo.

19. (a) 2-15-44 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2/13 day ..... year 1944 hour 2 30 minute P M.

21. I hereby certify that I attended the deceased from Jan 17 1944 to Feb 13 1944 that I last saw her alive on Feb 12 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia — Duration 2 days

Due to Senile deterioration 1941

Due to age

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature C. E. Cossins (M. D. or other)

Address State Hospital # 2 St Joseph Mo Date signed 2/13 1944

1233

(Licensed Embalmer's Statement on Reverse Side)

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 Herman Wm Sidenfaden

Licensed Embalmer No. 2728

P. O. Address St Joseph Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 148

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph Mo.
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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 Annie Payne 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
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 27 (Day) 1866 (Year)
8. AGE: Years 77 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 3 year 1944 hour 6 minute M.
21. I hereby certify that I attended the deceased from 19, to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death Bronchial P
Due to
Due to 107
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. E. [illegible] (M. D. or other)
Address State Hospital #2 Date signed 3/7 1944

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

0554