

FILED JUL 25 1944

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 576

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly General Hospital, Springfield, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 58 days
In this community 58 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Earl Brown, Jr.

3. (b) If veteran, name war World War II 3. (c) Social Security No. und.

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased October 29 1917
(Month) (Day) (Year)

8. AGE: Years 26 Months 8 Days 12 If less than one day hr. min.

9. Birthplace Philadelphia, Pennsylvania 1
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Carpenter

12. Name Earl Brown, Sr.

13. Birthplace Philadelphia, Pennsylvania 1
(City, town, or county) (State or foreign country)

14. Maiden name Miriam R. Knabb

15. Birthplace Philadelphia, Pennsylvania 1
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Brown

(b) Address 808 Station Ave Haddon Heights, Md

17. (a) Removal (b) Date thereof July 23, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Haddon Heights (Haddonfield)

18. (a) Signature of funeral director H. C. D. [Signature]

(b) Address Springfield, Mo.

19. (a) 7-13-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State New Jersey (b) County Camden 999
(c) City or town Haddon Heights, New Jersey 28
(If outside city or town limits, write "RURAL")
(d) Street No. 808 Station Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1944 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 15
19 44 to July 11 19 44
that I last saw him alive on July 11 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Brain, tumor of, Duration
malignant glioblastoma, left,
lateral, ventricle 3 mo

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Left lateral ventricle tumor
Of autopsy Confirmation of above diagnosis 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 [Signature] (M. D. or other) MD
Address O'Reilly GH, Springfield, Mo Date signed 7-11-44

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

27
2
6

A report submitted to the Bureau of the Census

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 *L. Robert Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield, 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.