

I X29484

FILED OCT 6 1944
Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **320**

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1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Hubbard
 (c) Name of hospital or institution: State Hosp # 1 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1-29-44 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Leo S. Brown
 3. (b) If veteran, name war DK. 3. (c) Social Security No. DK.

4. Sex male 5. Color or race gr
 6. (a) Single, widowed, married, divorced DK
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: not given (Month) (Day) (Year)

8. AGE: Years 8 Months 5 Days 9 If less than one day hr. min.

9. Birthplace: mo (City, town, or county) Mo (State or foreign country)
10. Usual occupation: laborer

11. Industry or business: _____
12. Name: DK
13. Birthplace: DK (City, town, or county) Mo (State or foreign country)
14. Maiden name: DK
15. Birthplace: DK (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Record
 (b) Address _____
17. (a) Removal: Removal (b) Date thereof: 9-27-1944 (Month) (Day) (Year)
 (c) Place: burial or cremation: Kirkcubbin College

18. (a) Signature of funeral director: Hallace Funeral Home
 (b) Address: Fulton, Mo. D. L. Brown, Mgr.
19. (a) Date received local registrar: 9-27-1944 (b) John M. Moushaff (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County St. Charles
 (c) City or town St. Charles 14 (If outside city or town limits, write "RURAL")
 (d) Street No. 2 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 20 year 1944 hour 10 minute 2 M.
21. I hereby certify that I attended the deceased from 8-17-1944 to 9-20-1944
 that I last saw him alive on 9-20-1944 and that death occurred on the date and hour stated above.

Immediate cause of death: chronic myocardial infarction
 Due to _____

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

Major findings: 1381
 Of operations _____
 Of autopsy _____

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: R. E. Starnell (M. D. or other)
 Address: Fulton, Mo Date signed: 9/20/44

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 10-5-44

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, _____
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Licensed Embalmer No. 4168

P. O. Address Fulton, 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.