

FILED DEC 30 1944

Registration District No. 327

Primary Registration District No. 4484

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Commerce
(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 20 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Scott 100
(c) City or town Commerce
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME JOSIAH MEANS BROWN

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ANNA BROWN 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased ARRIL 17 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 2 If less than one day hr. min.

9. Birthplace NASHVILLE ILL. (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER { 12. Name ZED. CARR BROWN
13. Birthplace NASHVILLE ILL. (City, town, or county) (State or foreign country)
14. Maiden name DONT KNOW
15. Birthplace DONT KNOW (City, town, or county) (State or foreign country)

16. (a) Informant ANNA BROWN
(b) Address Commerce
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-21-1944 (Month) (Day) (Year)
(c) Place: burial or cremation OAKDALE CEMETARY

18. (a) Signature of funeral director Charles H. ...
(b) Address
19. (a) See 21-44 (Date received local registrar) (b) Jan L. ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19 year 1944 hour ✓ 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. Senile Dementia Duration 8 yr

Due to _____
Due to 1670
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
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?

While at work (Specify type of place) (e) Means of injury
23. Signature Leide ... (M.D. or other) Address ... Mo. Date signed 12/19/44

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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 Marnie Buplinghoff
Licensed Embalmer No. 3242
P. O. Address Choffee 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.