

TYPEPRINT
IN
PERMANENT
BLACK INK.
FOR
INSTRUCTIONS
SEE OTHER SIDE
AND HANDBOOK.

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

Filed March 26, 1999

124 - 44 - 042378

REGISTRATION DISTRICT NO. 067

REGISTRAR'S NUMBER Delayed 234993

DECEDENT

NOTARIZED STATEMENT
A RECORD OF THE
PICTURE OF THE GRAVE
FOR THE DECEASED
BY MISSOURI DEPARTMENT OF HEALTH

PARENTS

INFORMANT

DISPOSITION

INSTRUCTIONS
OF AZ
JEFFERYS.
AND A
MARCH 15/44

CAUSE OF DEATH

FILED ON THE BASIS
FROM LEOTA L.
MORTICIANS'S NOTES
MARKER. PASSED AWAY

CERTIFIER

1. DECEDENT'S NAME (First, Middle, Last) **JUDD ALFORD BROWN** 2. SEX **Male** 3. DATE OF DEATH (Month, Day, Year) **March 15, 1944**

4. SOCIAL SECURITY NO. _____ 5a. AGE - Last Birthday (Years) **80** 5b. UNDER 1 YEAR MONTHS _____ DAYS _____ 5c. UNDER 1 DAY HOURS _____ MINUTES _____ 6. DATE OF BIRTH (Month, Day, Year) **Oct. 1, 1865** 7. BIRTHPLACE (City and State or Foreign Country) **West Plains, Mo.**

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes No Unk. 9a. PLACE OF DEATH (Check only one; see instructions on other side) **HOSPITAL:** Inpatient ER/Outpatient DOA **OTHER:** Nursing Home Residence Other (Specify) _____

9b. FACILITY NAME (If not institution, give street and number) _____ 9c. CITY, TOWN, OR LOCATION OF DEATH **Drury** 9d. COUNTY OF DEATH **Douglas**

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify) **Married** 11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) **Mary Jane Dobbs Brown** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) **Farmer** 12b. KIND OF BUSINESS OR INDUSTRY _____

13a. RESIDENCE - STATE **Missouri** 13b. COUNTY **Douglas** 13c. CITY, TOWN, OR LOCATION **Rt. 1, Drury** 13d. ZIP CODE _____

13a. STREET AND NUMBER **Rt. 1, Drury** 13f. INSIDE CITY LIMITS Yes No 13g. YEARS AT PRESENT ADDRESS Under 5 5-9 10-19 20 or more

14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No Yes Specify: _____ 15. RACE - American Indian, Black, White, etc. (Specify) **White** 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) **0** College (1-4 or 5+) _____

17. FATHER'S NAME (First, Middle, Last) **Michael Brown** 18. MOTHER'S NAME (First, Middle, Maiden Surname) **Ann Crabtree**

19a. INFORMANT'S NAME (Type/Print) **Judy Jefferys** 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **6200 S. Hillcrest Dr. Okla. City, Ok. 73159**

20a. BURIAL, CREMATION, OTHER (Specify) **Burial** 20b. DATE OF DISPOSITION (Month, Day, Year) **March 18, 1944** 20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **Pleasant Home** 20d. LOCATION - City or Town, State **Drury, Mo.**

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH **Judy L. Jefferys** 22a. NAME AND ADDRESS OF FACILITY **NA** 22b. FUNERAL ESTABLISHMENT LICENSE NUMBER **Na**

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Kidney failure**
 IMMEDIATE CAUSE (Final disease or condition resulting in death)
 DUE TO (OR AS A CONSEQUENCE OF):
 a. _____
 b. _____
 c. _____
 d. _____
 UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? Yes No Unk. 25a. WAS AN AUTOPSY PERFORMED? Yes No 25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes No

26. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide 27a. DATE OF INJURY (Month, Day, Year) _____ 27b. TIME OF INJURY **M** 27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) Yes No Unk. 27d. INJURY AT WORK? Yes No Unk. 27e. DESCRIBE HOW INJURY OCCURRED _____

27f. PLACE OF INJURY - At home, farm street, factory, office building, etc. (specify) _____ 27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____

28a. (Specify) CERTIFYING PHYSICIAN MEDICAL EXAMINER/CORONER 28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) **Unknown** 28c. DATE SIGNED (Month, Day, Year) _____ 28d. TIME OF DEATH _____

29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) _____ 29b. MO. LICENSE NUMBER _____ 30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes No

31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) _____ 32. REGISTRAR'S SIGNATURE _____ 33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) _____

DO NOT WRITE ON THIS STUB	7-cy	12a	23u	27g-co
	9a	13e	23-sc1	29g-cy
	9b	13b	27-sc2	29a
	9c	14	27e-f	29b
	12b	15	27g-st	

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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____ Signature of Student Embalmer
Signed _____ Licensed Embalmer No. _____

NAME OF DECEDENT _____ P.O. Address _____

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the chain of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE OF PHYSICIAN CERTIFICATION:	23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death													
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 2px;">IMMEDIATE CAUSE → <small>(Final disease or condition resulting in death)</small></td> <td style="width: 5%; padding: 2px;">a.</td> <td style="padding: 2px;"><u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):</td> <td style="width: 10%; padding: 2px;">Mins</td> </tr> <tr> <td rowspan="3" style="padding: 2px;">Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST</td> <td style="padding: 2px;">b.</td> <td style="padding: 2px;"><u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):</td> <td style="padding: 2px;">6 days</td> </tr> <tr> <td style="padding: 2px;">c.</td> <td style="padding: 2px;"><u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):</td> <td style="padding: 2px;">5 years</td> </tr> <tr> <td style="padding: 2px;">d.</td> <td style="padding: 2px;"> </td> <td style="padding: 2px;"> </td> </tr> </table>	IMMEDIATE CAUSE → <small>(Final disease or condition resulting in death)</small>	a.	<u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):	Mins	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b.	<u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):	6 days	c.	<u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):	5 years	d.		
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26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) _____	27b. TIME OF INJURY _____ M.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27d. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27e. DESCRIBE HOW INJURY OCCURRED _____	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____									

EXAMPLE OF MEDICAL EXAMINER OR CORONER	23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death													
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