

FILED FEB 15 1945

State File No.

Registration District No. 15

Primary Registration District No. 3004

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Barton County
 (b) City or town Lamar
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
213 No. Broadway
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community 46 Years / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton 6
 (c) City or town Lamar /
 (If outside city or town limits, write "RURAL")
 (d) Street No. 213 No. Broadway /
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME TIMOTHY BROWN

3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife Marie Jane Brown
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased April 9, 1858
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10,
 year 1945 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from Jan 6 1945 to Jan 10 1945
 that I last saw him alive on Jan 10
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Duration 4 days

8. AGE: Years Months Days If less than one day
86 9 1 hr. min.

Due to.....
 Due to.....

9. Birthplace X IOWA /
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Retd. Farmer

Major findings: Of operations.....

11. Industry or business.....

Of autopsy.....

12. Name James Brown

13. Birthplace Ireland /
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown
 15. Birthplace Unknown /
 (City, town, or county) (State or foreign country)

16. (a) Informant J. F. Brown
 (b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof 1-13-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address Carthage, Missouri

19. (a) Jan. 11, 1945 (b) E. C. Gibson
 (Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. [Signature])
 Address Lamar Mo Date signed 1/11/45

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

MOTHER FATHER

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..... *Ed Williams*

.....
Licensed Embalmer No..... *2272*

P. O. Address..... *Carthage*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1615
Registrar's No. 2

Registration District No. 15 Primary Registration District No. 3004

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

1. PLACE OF DEATH:
(a) County Barton
(b) City or town Jamaar
(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 _____)
In this community 4 6 years (years, months or days)

3. (a) PRINT FULL NAME Timothy 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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 9 1945 (Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days _____ If less than one day _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Brown
13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name unk.

15. Birthplace unk. (City, town, or county) (State or foreign country)

16. (a) Informant J. F. Brown
(b) Address Kansas City, MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-45 (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed C. Ulmer
(b) Address Carthage, Mo.

19. (a) March 26 45 (Date received local registrar) (b) Matthia River (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Barton
(c) City or town Jamaar (If outside city or town limits, write "RURAL")
(d) Street No. 213 No. Broadway (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan Day 10 Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Jan 10 1945 to Jan 10 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Duration 4 days

Due to _____
Due to _____

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 E. C. Hession (M. D. or other) _____
Address Jamaar, Mo Date signed 11-45

SUPPLEMENTAL

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 345-368

Date Filed MAR 29 1945