

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Walker
State File No. 134207
Registrar's No. 9

Registration District No. 133

Primary Registration District No. 5489

1. PLACE OF DEATH:
 (a) County Harrison
 (b) City or town Melbourne Sugar Creek Twp
(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 years, months or days)
 In this community 9 Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO. (b) County Harrison
 (c) City or town Melbourne, Mo.
(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 Alice A. Brown
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife John Brown 6. (c) Age of husband or wife if alive 79 years
 7. Birth date of deceased Sept. 4 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 20 If less than one day hr. _____ min. _____

9. Birthplace Harrison Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER
 12. Name John S. Hudson
 13. Birthplace Penn.
(City, town, or county) (State or foreign country)
 14. Maiden name Arbellia Hughs
 15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Paul M. Brown
 (b) Address Melbourne, Mo.

17. (a) Burial (b) Date thereof 1-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mitchell

18. (a) Signature of funeral director Martin Funeral Home
 (b) Address Princeton, Mo.

19. (a) Jan 27-1945 (b) Zola M. Burres
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
 year 1945 hour 12 minute 30 P. M.
 21. I hereby certify that I attended the deceased from Dec 29 1944 to Jan 25 1945
 that I last saw her alive on Jan - 25 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Intestinal Nephritis
 Duration 24da

Due to Chronic Myocarditis

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

Major findings: Of operations 13/11
 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) (c) Means of injury _____
 23. Signature W. C. Walker Date signed 1-25
 Address Wilman C. Ely

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

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, ~~and~~ by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

H. Evan Martin

Licensed Embalmer No. _____

3760

P. O. Address _____

Sumner, MD

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.