S. No. 2
M—5-42
. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16887

Primary Registration District No. 2000

Registrar's No. 420

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 611½ Washington Ave. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether

In this community ✓ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield (If outside city or town limits, write "RURAL")

(d) Street No. 611½ Washington (If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Albert Brown.

3. (b) If veteran, name was UNK. ✓

3. (c) Social Security No. UNK.

4. Sex Male

5. Color or race Col.

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased UNK. (Month) UNK. (Day) 1902 (Year)

8. AGE: Years 43 Months UNK. Days UNK. If less than one day ___ hr. ___ min.

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

10. Usual occupation Laborer

11. Industry or business ✓

FATHER
12. Name Nancy Walker
13. Birthplace UNKNOWN (City, town, or county) Missouri (State or foreign country)

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

16. (a) Informant Ida Fisher

(b) Address 628 E. Brower, Spfd, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-45 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Mem.

18. (a) Signature of funeral director W. P. Campbell

(b) Address 867 Washington, Spfd, Mo.

19. (a) 5-24-45 (Date received local registrar) (b) Dr W. E. Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 20 year 1945 hour 9 minute 30a M.

21. I hereby certify that I attended the deceased from 5/18/45, 19__, to 5/18, 1945, that I last saw him alive on 5/18/45, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Mitral regurgitation Myocarditis	
Due to: Rheumatism Shoulder	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 92 b	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature A. E. Reeder (M. D. or other) M.D.

Address Springfield Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

JAN 23 1947

MAR 11 1946

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 W. P. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield M

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.