

FILED NOV 21 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 5575

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kennett, Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5810 Angeleno Drive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 9 yrs years, months or days)

3. (a) PRINT FULL NAME CORA L. BROWN

3. (b) If veteran, name war _____ 3. (c) Social Security No. 70

4. Sex Female 5. Color or race wh 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Harry J. Brown 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased June 24 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Eustace Rall
13. Birthplace Bermain
(City, town, or county) (State or foreign country)
14. Maiden name Emma Traubel
15. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. J. Brown

(b) Address Kennett Mills, Mo

17. (a) Burial (b) Date thereof Oct 25-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (c) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Kansas City Mo

19. (a) Oct. 24-45 (b) Dr. Annie B. Hedger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kennett Mills
(If outside city or town limits, write "RURAL")
(d) Street No. 5810 Angeleno Drive
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23
year 1945 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 10
1945 to Oct 23 1945
that I last saw her alive on Oct. 18 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary heart disease yrs.

Due to Arteriosclerosis complicated by nephritis and diabetes

Other conditions _____

Major findings: Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Annice B. Hedger (M. D. or other) DO
Address Kennett Mills Mo Date signed 10/23/45

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed.....

C. H. White

..... Licensed Embalmer No. *2570*

..... P. O. Address. *K @ 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 78

Registration District No. 154 Primary Registration District No. 5575

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Washington 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
In this community _____ years, months or days) (Specify whether

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

3. (a) PRINT FULL NAME Cora L. Brown
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 24 1878
(Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

Due to _____
Due to Nephritis chronic, becoming acute at the last, due to causes previously mentioned.
Other conditions _____
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

37417