

S. No. 2  
DM-5-43  
5-17-39  
I X36671

State File No. \_\_\_\_\_

**FILED JUN 10 1946**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 635

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
802 Dewey  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 Years  
years, months or days

3. (a) PRINT FULL NAME James Brown

3. (b) If veteran, name war No 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 Catherine 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 18 1863  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>0</u>	<u>13</u>	hr. _____ min.

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

10. Usual occupation Retired Plumber (20)

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Not Known

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

14. Maiden name Mary Cole

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

16. (a) Informant Mrs. Frank Alumbaugh

(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 6-3-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc.  
(b) Address St Joseph, Mo.

19. (a) June 5, 1946 (b) W. McCallister  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 802 Dewey  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31  
year 1946 hour 1 minute 20 A.M.

21. I hereby certify that I attended the deceased from 30 May  
1946 to 31 May 1946;  
that I last saw him alive on 31 May 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>myocardial decompensation</u>	<u>6 hours</u>
Due to <u>Generalized and coronary atherosclerosis</u>	<u>2 years</u>
Due to <u>Cerebral arteriosclerosis</u>	<u>2 years</u>
<u>Semipathy</u>	<u>3 years</u>
Other conditions <u>Achylus ulcer</u>	<u>2 years</u>
(Include pregnancy within 3 months of death)	

Major findings:  
Of operations none  
Of autopsy none

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 fall

23. Signature Thompson E. Potter (M. D. or other) M.D.  
Address 415 Co. Bldg. St Joseph, Mo. Date signed June 4 1946

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

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**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..... *Robert H. Gaylor* .....

Licensed Embalmer No. *3308* .....

P. O. Address..... *St. Joseph, 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.**