. S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26292

FILED AUG 12 1946

Registration District No. ____ Primary Registration District No. 1000 Registrar's No. 898

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph Mo — (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs — (Specify whether In this community 6 hrs — years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town ~~Newborn~~ St. Joseph, Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 2914 No. 8th St. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Dale Allen Brown

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased Aug. (Month) 8 (Day) 1946 (Year)

8. AGE: Years — Months — Days — If less than one day 6 hr. ____ min.

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

10. Usual occupation Newborn

11. Industry or business —

FATHER
12. Name JAMES G. BROWN
13. Birthplace St Joseph (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Winona Marcelle Albertson
15. Birthplace St Joseph (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mr. James G. Brown

(b) Address 2914 N. 8th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Mier Hoffer

(b) Address 802 Faraon St. St. Joseph, Mo.

19. (a) Aug. 10, 1946 (Date received local registrar) A. J. Nicolaus (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9th year 1946 hour 1:00 minute 6 M.

21. I hereby certify that I attended the deceased from 6:00 P.M. Aug. 8, 1946 to 1:00 AM Aug 9, 1946 that I last saw him alive on Aug 9, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Fetal atelectasis

Due to Prematurity

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 159

Of autopsy

Duration

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 E. E. Wadlow (M. D. or other)

Address 620 Francis St Joseph Date signed 8-9-46

54 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed. Elbert C. Harrington

Licensed Embalmer No. 3258 Mo.

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.