

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

STANDARD CERTIFICATE OF DEATH

30854

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

Registration District No. 175

Primary Registration District No. 5646

Registrar's No. 103

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Buckprarie Twn Ship
(c) Name of hospital or institution:
(d) Length of stay: In hospital or institution. Life
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Rural
(d) Street No. R.F.D. # 1 Aurora Mo.
(e) Citizen of foreign country? No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1946 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from
Apr 21 1946 Sept 25 1946
that I last saw him alive on Sept 24 1946
and that death occurred on the date and hour stated above.

Immediate cause of death:
Sailor's
Due to: crew of a steamer.

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

Major findings:
Of operations:
Of autopsy:
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?
Signature: A.P. Pettit
Address: Aurora, Mo. Date signed: 9-29-46

3. (a) PRINT FULL NAME James Moore Brown

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

4. Sex Male Color or race White
5. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Delila Brown
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 14 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 11
If less than one day hr. min.

9. Birthplace Lawrence County Mo.

10. Usual occupation Farmer

11. Industry or business Retired

12. Name John Brown

13. Birthplace Bedford County Tenn.

14. Maiden name Mary Lassiter

15. Birthplace Bedford County Tenn.

16. (a) Informant Mr Arley Brown,

(b) Address R 1 Aurora Mo.

17. (a) Burial (b) Date thereof Sept, 29/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville Mo.

18. (c) Signature of funeral director J.B. Humidge

(b) Address Marionville Mo.

19. (c) 9-29-46 (b) Ora McNett
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 6

District File Number 1046-1032

Date Filed OCT 8 - 1946

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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 Herman Surridge  
Licensed Embalmer No. 3072  
P. O. Address Marionville

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. Oct  
Registrar's No. 103

Registration District No. 175 Primary Registration District No. 5646

1. PLACE OF DEATH  
(a) County Lawrence  
(b) City or town Rural  
(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)

3. (a) PRINT FULL NAME James M. Brown  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 14 (Month) (Day) (Year)  
8. AGE: Years 77 Months 7 Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 arterio-sclerosis - a ruptured cerebral artery  
Due to arterio-sclerosis  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 97

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

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SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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