

FILED OCT 17 1946

Registration District No. 7Primary Registration District No. 5033

Registrar's No. ....

## 1. PLACE OF DEATH:

(a) County Audrain  
 (b) City or town R.F.D.#1, Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 42 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME David Nathan Brown

3. (b) If veteran, none name war  
 3. (c) Social Security No. none

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dena Brown  
 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased April 10 1861  
 (Month) (Day) (Year)

8. AGE: Years: 85 Months: 5 Days: 11  
 If less than one day hr. min.

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

10. Usual occupation retired farmer

## 11. Industry or business

12. Name Abraham Brown

13. Birthplace Pennsylvania  
 (State or foreign country)

14. Maiden name Susan Storks

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

16. (a) Informant Martinsburg, Missouri

(b) Address burial

17. (a) (Burial, cremation, or removal) Elmwood Cemetery  
 (b) Date thereof 9 23-46  
 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Earl E. Pugh

(b) Address Mexico, Missouri

19. (a) Sept. 28, 46 (b) Max Joe Carter  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain  
 (c) City or town R.F.D.#1, Martinsburg  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 0  
 (If rural, give location) 0  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country: .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21  
 year 1946 hour 4 Black minute 0 M.

21. I hereby certify that I attended the deceased from Crown Case 19.....

that I last saw him alive on ..... 19.....  
 and that death occurred on the date and hour stated above.

Immediate cause of death Star found dead at Duration

his home 3 1/2 miles West of

Martinsburg Mo. No evidence of

Due to poor play. Probably heart

failure. Myocardium

Due to blind unattended by a

physician

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings: .....

Of operations: .....

Of autopsy: None 93E

## 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? .....

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

While at work? no (Specify type of place)

(e) Means of injury none

23. Signature S. C. Adams (M. D. or other) Coroner

Address Mexico, Mo. Date signed 9-22-46

RECEIVED  
District Health Officer No. 10  
Dist. File Number 10-46-18  
Date Filed OCT 14 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.....

**Earl E. Precht**

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

working under my personal supervision.

Signed..... *Earl E. Precht* .....

Licensed Embalmer No. **3189** .....

P. O. Address..... **Mexico. Missouri** .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 7

Primary Registration District No. 5033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Madison  
 (b) City or town Rural Lottree  
(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

David 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 M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

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

8. AGE: Years 85 Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

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

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 CERTIFICATE

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

32620