

S. No. 2
OM-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32896**
Registrar's No. **266**

Registration District No. **47** Primary Registration District No. **3008**

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2
31724
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Collaway

(b) City or town Hulbert
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hospital #12
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 mo 28 d
(Specify whether years, months or days)

In this community 6 mo 28 d

3. (a) PRINT FULL NAME WARREN 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 single

6. (b) Name of husband or wife /

6. (c) Age of husband or wife if alive 18 years (Day) (Year)

7. Birth date of deceased Sept 18 1896
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>10</u>	<u>15</u>	hr. <u>0</u> min. <u>0</u>

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

10. Usual occupation Farm laborer

11. Industry or business Farm

MOTHER FATHER {

12. Name James Brown

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

14. Maiden name Malinda

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

16. (a) Informant Hospital records

(b) Address Hulbert Mo

17. (a) Hulbert Mo Date thereof 2-1946
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation buried in Mo

18. (a) Signature of funeral director [Signature]

(b) Address Hulbert Mo

19. (a) 8-2-1946 (b) Josie Mosekoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard

(c) City or town Bayette
(If outside city or town limits, write "RURAL")

(d) Street No. /
(If rural, give location)

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

If yes, name country /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2 year 1946 hour / minute 7:15 M.

21. I hereby certify that I attended the deceased from 6/27/46 to 8/2/46 that I last saw him alive on 8/2 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to /

Due to /

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

Major findings: Of operations g2D

Of autopsy /

22. If death was due to external causes, fill in the following:

(c) 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 0

Signature [Signature] (M. D. or other) Mo

Address Hulbert Mo Date signed 8/2/46

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.....
Licensed Embalmer No. 2555
P. O. Address.....

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.