

No. 2  
5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 19 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **43464**  
Registrar's No. **1**

Registration District No. **107**

Primary Registration District No. **5424**

**1. PLACE OF DEATH:**  
 (a) County Dunklin  
 (b) City or town Campbell Rural  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1  
(Specify whether)  
 In this community Life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Dunklin  
 (c) City or town Campbell Rural  
(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 \_\_\_\_\_

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

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month December day 19  
 year 1946 hour \_\_\_\_\_ minute 7:15 A.M.  
**21. I hereby certify that I attended the deceased from** Oct 10  
1946, to December 18, 1946  
 that I last saw her alive on December 18, 1946  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Spina Bifida  
and Meningocele

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Child  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased October 10 1946  
(Month) (Day) (Year)

Duration Life  
 Physician \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

**8. AGE:** Years \_\_\_\_\_ Months 2 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Infant

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

12. Name Billy Brown

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

14. Maiden name Loid Coleman

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

16. (a) Informant Loid Brown

(b) Address Campbell, MO R. 1

17. (a) Burial (b) Date thereof 12-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Bethany

18. (a) Signature of funeral director Loidess Funeral Home  
 (b) Address Campbell, MO  
 19. (a) 1/21/47 (b) Mrs. Beulah Campbell  
(Date received local registrar) (Registrar's signature)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**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)  
 (e) Means of injury F  
 Signature F O Kelley D.P. M.D. or other \_\_\_\_\_  
 Address Bessie, MO Date signed 1-24-47

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

92

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 147-166

Date Filed 1-30-47

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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.....

Licensed Embalmer No.....

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.