

S. No. 2  
M-5-43  
5-17-39  
I-X35671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21605

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

Registration District No. 209

Primary Registration District No. 3042

Registrar's No. 228

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: ST. Elizabeth Hospital  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

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

(d) Street No. 419 N. 9th  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph N. Brown

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17  
year 1947 hour \_\_\_\_\_ minute 6<sup>30</sup> P.M.

21. I hereby certify that I attended the deceased from May 16-47  
to May 17-47  
that I last saw him alive on May 17-47  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Colored

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 October 10, 1923  
(Month) (Day) (Year)

Immediate cause of death Refluxion?

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

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

8. AGE: Years Months Days If less than one day

23 7 7 hr. \_\_\_\_\_ min.

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

Major findings: Of operations 10

Of autopsy \_\_\_\_\_

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

10. Usual occupation Laborer

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

12. Name Frank M. Brown

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

14. Maiden name Susie Lehmeier

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Frank Brown

(b) Address 418 N. 9th Harribal Mo

17. (a) Burial (b) Date thereof May 21, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baptist Cem.

18. (a) Signature of funeral director James O. Council

(b) Address Harribal Mo

19. (a) 6-10-47 (b) Dr E W Luckey  
(Date received local registrar) (Registrar's signature)

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

Address [Address] Date signed 5/17/47

(Licensed Embalmer's Statement on Reverse Side)

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

1  
2  
3  
4

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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..... *H. M. O'Connell* .....

Licensed Embalmer No. *3889* .....

P. O. Address..... *Hannibal 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.**