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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27321

Registration District No. 12847

Primary Registration District No. 2000

Registrar's No. 727

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1607 E. Central /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 76 years _____ (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
 (c) City or town Springfield 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1607 E. Central 6
 (If rural, give location) 0
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country 76 Years

3. (a) PRINT FULL NAME Nancy Susan Brown
 3. (b) If veteran, name war No
 3. (c) Social Security No. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19 1947
 year 1947 hour 3 minute P.M.

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife James T. Brown
 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased Jan. 16 1871
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Aug 19, 1947 to Aug 19, 1947
 that I last saw h ct alive on Aug 19, 1947
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>7</u>	<u>3</u>	hr. min.

Immediate cause of death
Cerebral Occlusion

Due to Arterio-Sclerosis

Duration
2 hrs

9. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

11. Industry or business _____
 12. Name James Calvin Smalling
 13. Birthplace Tenn.
 (City, town, or county) (State or foreign country)
 14. Maiden name Josephene Dennis
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. John Dodson
 (b) Address 1620 E. Central
 17. (a) Burial (b) Date thereof Aug 22/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation East Lawn Cemetery
 18. (a) Signature of funeral director W. J. ... Co
 (b) Address ... Mo.
 19. (a) 8-22-47 (b) W. J. ...
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature Max ... (M. D. or other) M.D.
 Address Springfield Mo. Date signed 8-21-47

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

Max Rhodes

Licensed Embalmer No.

4071

P. O. Address

Springfield

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.