

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30221**

FILED OCT 7 1947
Registration District No. _____

Primary Registration District No. **4009**

Registrar's No. **198**

1. PLACE OF DEATH:

(a) County **Andrew**

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

(c) Name of hospital or institution:
610 Chestnut St 1
(If not in hospital or institution, write street number or location)

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

In this community **70 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Andrew**

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

(d) Street No. **610 Chestnut**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James Albert Brownlee**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **20**
year **1947** hour **5** minute **30 A.M.**

4. Sex **MALE**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **MR**

6. (b) Name of husband or wife **Elizabeth Brownlee**

6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **9-22-1876**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **5-15-1947** to **8-7-47**, 19____
that I last saw him alive on **8-7-47**, 19____
and that death occurred on the date and hour stated above.

8. AGE: Years **70** Months **0** Days **2**
If less than one day _____ hr. _____ min.

Immediate cause of death **Coronary Thrombosis**

Due to **arteriosclerosis & hypertension**

Due to _____

9. Birthplace **MODAWAY IOWA**
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation **Retired Burlington Depot Agent**

Major findings: Of operations **94A**

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **William Brownlee**

13. Birthplace **unknown Ill.**
(City, town, or county) (State or foreign country)

14. Maiden name **Rebecca McDonald**

15. Birthplace **unknown Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. A. Brownlee**

(b) Address **Empire Hotel Omaha nebr.**

17. (a) _____ (b) Date thereof **9-22-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **SAVANNAH**

18. (a) Signature of funeral director **E. B. Breit**

(b) Address **SAVANNAH MO**

19. (a) **9-22-47** (b) **William Spink**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (b) Means of injury _____

23. Signature **Donald Cherry** (M. D. or other) **MD**

Address **Savannah Mo** Date signed **9/24/47**

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

JUL 2 1948

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 E. C. Breit
Licensed Embalmer No. 2650
P. O. Address Savannah 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.