

S. No. 300  
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I 3906

MISSOURI DIVISION OF HEALTH  
National Office of Vital Statistics  
FILED APR 12 1948  
Registration District No. 183

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
Primary Registration District No. 4296

State File No. 9326  
Registrar's No.

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

8000

1. PLACE OF DEATH: **HOME**  
(a) County **Browning**  
(b) City or town **Browning**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Linn** 58  
(c) City or town **Browning** 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

3. (a) PRINT FULL NAME **James Warner Brassfield**  
3. (b) If veteran, name war ---  
3. (c) Social Security No. ---

4. Sex **M** 0 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Essie Ann Brassfield** 6. (c) Age of husband or wife if alive **61** years  
7. Birth date of deceased: **June 7 1884**  
(Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **16**  
If less than one day hr. min.

9. Birthplace: **MISSOURI**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Stock Buyer**

11. Industry or business **James N. Brassfield**

12. Name **James N. Brassfield**  
13. Birthplace **MO** (State or foreign country)

14. Maiden name **Rachel Rover**  
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. ESSIE Ann Brassfield**  
(b) Address **Browning**

17. (a) **Burial** (b) Date thereof **3-25-48**  
(Burial, cremation, or removal) (City or town) (County) (State) (Month) (Day) (Year)  
(c) Place: burial or cremation **Losust Valley**

18. (a) Signature of funeral director **Wade funeral home**  
(b) Address **Browning, MO.**

19. (a) **1948/3/1/1948** (b) **Elva Crookshank**  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **23** year **1948** hour **11** minute **45** P.M.

21. I hereby certify that I attended the deceased from **Feb 10 1948** to **March 23 1948**  
that I last saw him alive on **March 23 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **Stasis pneumonia** Duration **12 hours**  
**(Bronchial)**  
**Acute Myocarditis**

Due to  
Due to

Other conditions **Carcinoma of Prostate & bladder**  
(Include pregnancy within 3 months of death)

Major findings: **diagnosis**  
Of operations  
Of autopsy **51B**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

Signature **J.R. Mearty** (M. D. or other)  
Address **Browning, Mo** Date signed

DISTRICT HEALTH OFFICE  
Cameron, Mo

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 Gerald F. Wade

Licensed Embalmer No. 4172

P. O. Address Browning

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.