

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

18673
State File No. _____
Registrar's No. 168

FILED JUN 25 1948

Registration District No. 32

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Granau Convalescent Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Months
(Specify whether
In this community Lifetime
years, months or days)

3. (a) PRINT FULL NAME LULA BROWN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife B.J. Brown 6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased 2 21 1858
(Month) (Day) (Year)

8. AGE: Years 90 Months 3 Days 25 If less than one day
hr. min.

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

10. Usual occupation At Home

11. Industry or business _____
MOTHER FATHER { 12. Name Philip Prather
13. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Georgla Ann Nichols
15. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Fred C. Brown
(b) Address 503 W. Broadway, Columbia, Mo.

17. (a) Burial (b) Date thereof 6-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia, Mo.

19. (a) 6-19-48 (b) Mrs. R.E. Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
(c) City or town Columbia 1
(If outside city or town limits, write "RURAL")
(d) Street No. 503 W. Broadway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1948 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from November 25
1947 to June 16 1948
that I last saw her alive on June 15 1948
and that death occurred on the day and hour stated above.

Immediate cause of death Broncho pneumonia
Fractured neck
of left femur.
Due to _____
Due to _____

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 118
(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)
(c) Means of injury _____

23. Signature Robert S. Simpson M. D. or other MD
Address Columbia Mo Date signed 6/18/48

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

RECEIVED
District Health Officer No. 3
District File Number
Date Filed JUN 24 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 *Thas L. Loring*
Licensed Embalmer No. *4132*
P. O. Address *Columbia, Md.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 1168

Registration District No. 38

Primary Registration District No. 2006

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Lula Brown

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

4. Sex F 5. Color or race w 6. (e) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased July 2 (Month) (Day) (Year)

8. AGE: Years 90 Months 3 Days _____ (If less than one day, hr. min.)

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ days on _____ and that death occurred on the date and hour stated above. Immediate cause of death broncho pneumonia Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) accidental fall.

(b) Date of occurrence About November 22, 1947.

(c) Where did injury occur? at her home, Columbia, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home.

While at work? _____ (Specify type of place) (e) Means of injury accidental fall

23. Signature Robert A. Jensen (M. D. or other) _____

Address _____ Date signed 6/29/48

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

SUPPLEMENTARY

S-18673