

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3999

State File No. _____

REG. DIST. NO. 27 PRIMARY REG. DIST. NO. 4033 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY <u>Bates</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rockville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rockville</u>	
c. LENGTH OF STAY (in this place) <u>10 yrs</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u>		b. (Middle) <u>Mae</u>	
		c. (Last) <u>Brown</u>	
		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 1-1949</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>September 25, 1890</u>
		9. AGE (in years last birthday) <u>78 yrs.</u>	if UNDER 1 YEAR: (Month) (Day) (Year) <u>4 3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Jamestown, Illinois</u>
			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Lewis Tschannen</u>		13b. MOTHER'S MAIDEN NAME <u>Kathryn Hager</u>	
		14. NAME OF HUSBAND OR WIFE <u>William J. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
		17. INFORMANT'S SIGNATURE OR NAME <u>Maie Surrage</u> ADDRESS <u>Nevada, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myo-cardial failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Inflammatory Phlebotomy</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u> m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>12/1</u> , 1948, to <u>2/1</u> , 1949, that I last saw the deceased alive on <u>2/1</u> , 1949, and that death occurred at <u>2:40 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Harry H. Williams, D.O.</u>		23b. ADDRESS <u>Rockville, Mo.</u>	
		23c. DATE SIGNED <u>2/1/49</u>	
24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 3, 1949</u>	
		24c. NAME OF CEMETERY OR CREMATORY <u>Laffer Cemetery</u>	
		24d. LOCATION (City, town, or county) (State) <u>Vernon Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 18-49</u>		REGISTRAR'S SIGNATURE <u>Kimball Murray</u>	
		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis & Son</u> ADDRESS <u>Schell City, Mo</u>	

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

207

RECEIVED

District Health Officer No. 7,

District File Number 1-49-118

Date Filed 2-24-9

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Marion M. Lewis

Signed _____
Student Embalmer

Licensed Embalmer No. 3084

P. O. Address Schell City, 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.