

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15098

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>53</u>	PRIMARY REG. DIST. NO. <u>3010</u>	Registrar's No. <u>139</u>
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau, Mo</u>		
c. LENGTH OF STAY (in this place) <u>2 weeks</u>		d. STREET ADDRESS (If rural, give location) _____		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Osteopathic Hospital</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Paul</u>		b. (Middle) <u>Alphus</u>		c. (Last) <u>Brown</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>May-13-1949</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>1923</u> <u>Nov. 30, 1923</u>	9. AGE (In years last birthday) <u>25</u> 10. IF UNDER 1 YEAR Months <u>5</u> 11. IF UNDER 24 HRS. Hours <u>13</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>James Alphus Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Gunter Brown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-20-7802</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sarah E. Brown, Oak Ridge, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Metastatic Carcinoma of Lung</u> DUE TO (c) <u>Gastric Carcinoma</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myelitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>151X</u>
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No.</u>		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) _____		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>April 26, 1949</u> , to <u>May 13, 1949</u> , that I last saw the deceased alive on <u>May 13, 1949</u> , and that death occurred at <u>3:25 a. m.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>M. D. Nevill D.O.</u>		23b. ADDRESS <u>105 South Spain</u>		23c. DATE SIGNED <u>5/13/49</u>
24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 15, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>
24d. LOCATION (City, town, or county) (State) <u>Missouri</u>				
DATE REC'D BY LOCAL REG. <u>5-15-1949</u>		REGISTRAR'S SIGNATURE <u>G. G. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wilson, Stables, Seabough</u> <u>Oak Raon Mo</u>

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.4816
4

JUN 16 1949

RECEIVED

Sanitary Health Officer No. 4

File Number 549-68

5-23-4

AUG 31 1949

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

R. O. Laird

Signed _____

Student Embalmer

Licensed Embalmer No. 4538

P. O. Address *Jackson, 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.