

No. 300
10. 48

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

34972

State File No. 9233

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nineva Township Rural	
c. LENGTH OF STAY (In this place) 12 days		d. STREET ADDRESS (If rural, give location) Barnes Hospital, VER.	

3. NAME OF DECEASED (Type or Print)	a. (First) Jesse	b. (Middle) Frank	c. (Last) Brown	4. DATE OF DEATH (Month) (Day) (Year) Oct. 23 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 29, 1902	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (State or foreign country) Troy, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Robert L. Brown	13b. MOTHER'S MAIDEN NAME Annie Rinaman	14. NAME OF HUSBAND OR WIFE Henrietta Martinek Brown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs Henrietta M. Brown Troy, Missouri	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 18 mo.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myasthenia gravis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 156
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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? 7440
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22. I hereby certify that I attended the deceased from Oct. 11, 1949, to Oct. 23, 1949, that I last saw the deceased alive on Oct. 23, 1949, and that death occurred at 7:20 Am., from the causes and on the date stated above.

23a. SIGNATURE F. K. Bradley (Degree or title) M.D.	23b. ADDRESS Barnes Hospital	23c. DATE SIGNED 10/23/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/26/49	24c. NAME OF CEMETERY OR CREMATORY Troy Cemetery	24d. LOCATION (City, town, or county) Troy, Missouri (State) _____
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DATE REC'D BY LOCAL REG. OCT 27 1949	REGISTRAR'S SIGNATURE J. B. Rooster	25. FUNERAL DIRECTOR'S SIGNATURE Kemper Funeral Home	ADDRESS Troy, Missouri
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(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student
Student Embalmer

Signed

Joseph J. Marsh

Licensed Embalmer No. 3932

P. O. Address Troy, Missouri.

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.