

FILED AUG 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29002

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 161

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Arrow Rock, Mo</u> | |
| c. LENGTH OF STAY (In this place) <u>20 hrs</u> | | d. STREET ADDRESS (If rural, give location) <u>Arrow Rock, Mo</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Mem Hosp</u> | | | |

| | | | | | |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED a. (First) <u>Rosa</u> b. (Middle) <u>Caroline</u> c. (Last) <u>Brown</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 21 1950</u> | | |
|--|--|--|--|--|--|

| | | | | | | | | | | | | | |
|----------------------|--|-------------------------------|--|---|--|--------------------------------------|--|---|--|--|--|--|--|
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>Feb 7 - 1886</u> | | 9. AGE (In years last birthday) <u>64</u> | | 10. UNDER 1 YEAR Months _____ Days _____ | | 11. UNDER 10 HRS. Hours _____ Min. _____ | |
|----------------------|--|-------------------------------|--|---|--|--------------------------------------|--|---|--|--|--|--|--|

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Arrow Rock - Mo</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
|---|--|--|---|--|--|--|--|--|---|--|--|

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|
| 13a. FATHER'S NAME <u>Robert Banks</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Kuciora</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Frank Brown</u> | | | 15. ADDRESS <u>Arrow Rock, Mo</u> | | |
|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|

| | | | | | | | |
|--|--|-------------------------------------|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Frank Brown</u> ADDRESS <u>Arrow Rock, 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis & Nephritis</u> 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. <u>Uremia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Don't Know</u> <u>442 X</u> <u>Several Days</u> | |
|---|--|---|--|--|--|--|--|--|--|

| | | | | | | | |
|------------------------|--|----------------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 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) (Min.) | | 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 May 27, 1950, to Aug 21, 1950, that I last saw the deceased alive on Aug 20, 1950, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

| | | | | | |
|---|--|--|--|-----------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>Waite H. Madison M.D.</u> | | 23b. ADDRESS <u>Marshall, Missouri</u> | | 23c. DATE SIGNED <u>Aug 22-50</u> | |
|---|--|--|--|-----------------------------------|--|

| | | | | | | | |
|---|--|--------------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>8-24-50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Springton Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Arrow Rock, Mo</u> | |
|---|--|--------------------------|--|--|--|---|--|

| | | | | | | | |
|---|--|---|--|-----|--|--|--|
| DATE REC'D BY LOCAL REG. <u>Aug 24-1950</u> | | REGISTRAR'S SIGNATURE <u>Budney S. Gray</u> | | 385 | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Leslie M. ...</u> ADDRESS <u>...</u> | |
|---|--|---|--|-----|--|--|--|

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

RECEIVED 8/28/50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 8/28/50

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *E. J. [Signature]*
Student Embalmer No. _____

Licensed Embalmer No. 4220

P. O. Address Missell, 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.