

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13913**

FILED APR 20 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5464** Registrar's No. **378**

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

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Willard</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Willard, Missouri</b>	
c. LENGTH OF STAY (In this place) <b>2 months</b>		1390	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Home of Mrs Ervin Hickman</b>		d. STREET ADDRESS (If rural, give location) <b>0</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>James E.</b> b. (Middle) <b>Wellons</b> c. (Last) <b>Brower</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 10. - 53</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 4, 1867</b>	9. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days <b>6</b> Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (State or foreign country) <b>Greene County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>James Robinson Brower</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Spoon</b>	14. NAME OF HUSBAND OR WIFE <b>Widowed</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Ervin Hickman,</b>	ADDRESS <b>Willard, Mo</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized arteriosclerosis</b>		
	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 <b>Benign prostatic hypertrophy</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4500</b>	20. AUTOPSY? YES <input 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)
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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?
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22. I hereby certify that I attended the deceased from **April 9, 1953**, to **April 9, 1953**, that I last saw the deceased alive on **April 9, 1953**, and that death occurred at **3:30 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Dean Cunningham, M.D</b>	(Degree or title)	23b. ADDRESS <b>1715 Boonerville</b>	23c. DATE SIGNED <b>4-11-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 12, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Clear Creek</b>	24d. LOCATION (City, town, or county) (State) <b>5 miles S.W. of Willard, Mo</b>
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DATE REC'D BY LOCAL REG. <b>4-15-53</b>	REGISTRAR'S SIGNATURE <b>Edith Williams Reg.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Greenwade-Windle,</b>	ADDRESS <b>Willard, Mo</b>
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*Dr. Cunningham  
city 17520*

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**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 *Gene Hunter* \_\_\_\_\_

Licensed Embalmer No. *4739*

P. O. Address *Springfield, Ill*

**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.