

FILED APR 26 1954

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11229**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **398**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph		c. LENGTH OF STAY (In this place) 45 yrs.	c. CITY OR TOWN St. Joseph
d. FULL NAME OF HOSPITAL OR INSTITUTION 309 Blake St.		e. STREET ADDRESS (If rural, give location) 309 Blake St.	

3. NAME OF DECEASED (Type or Print)	a. (First) CHARLEY	b. (Middle) CLIFFORD	c. (Last) BROWN	4. DATE OF DEATH (Month) 4 (Day) 17 (Year) 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-6-1881	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Contractors	11. BIRTHPLACE (City and State or Foreign Country) Lincelon Co., Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME David L. Brown	13b. MOTHER'S MAIDEN NAME Mathilda Ludlow	14. NAME OF HUSBAND OR WIFE Martha May Brown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Martha May Brown	ADDRESS 309 Blake St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION St. Joseph, Mo.		INTERVAL BETWEEN ONSET AND DEATH 3 years
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angina Pectoris	DU TO (b) -		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DU 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 type="checkbox"/> NO <input checked="" 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)	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 **Feb. 1854**, to **April 17, 1954**, that I last saw the deceased alive on **Apr. 17, 1954** and that death occurred at **1:30 A.M.** m., from the causes and on the date stated above.

23a. SIGNATURE John H. Swail, M.D.	(Degree or title)	23b. ADDRESS Wathonia, Kans.	23c. DATE SIGNED 4/18/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-19-1954	24c. NAME OF CEMETERY OR CREMATORY MT. AUBURN	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. April 19, 1954	REGISTRAR'S SIGNATURE Garther M. Allison	485	25. FUNERAL DIRECTOR'S SIGNATURE John Rupp	ADDRESS St. Joseph, Mo.
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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, ~~only~~....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No... 39.....

P. O. Address..... St. Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.