

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **26897**

**FILED SEP 7 1954**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 828

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>Greene</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Campbell Twp</u> |  | c. CITY OR TOWN <u>Springfield</u>  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (In this place) <u>9 Years</u>   |  | e. STREET ADDRESS (If rural, give location) <u>18 Wayland Drive</u>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>18 Wayland Drive</u>  |  |   |   |

|                                     |                          |                       |                        |   |
|-------------------------------------|--------------------------|-----------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>JOSEPH</u> | b. (Middle) <u>L.</u> | c. (Last) <u>BROWN</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>September 2 1954</u> |
|-------------------------------------|--------------------------|-----------------------|------------------------|---|

|                    |                               |   |  |   |   |  |
|--------------------|-------------------------------|---|--|---|---|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>October 16, 1889</u> | 9. AGE (In years last birthday) <u>64</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 4 HRS. Hours _____ Min. _____ |
|--------------------|-------------------------------|---|--|---|---|--|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Engineer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>State Highway Dept</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Cass County, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|---|---|--|

|                                   |  |  |
|-----------------------------------|--|--|
| 13a. FATHER'S NAME <u>Unknown</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Corrine Brown</u> |
|-----------------------------------|--|--|

|  |                                    |  |                                 |
|--|------------------------------------|--|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u> | 16. SOCIAL SECURITY NO. <u>Yes</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Corrine Brown, Springfield, Mo.</u> | ADDRESS <u>Springfield, Mo.</u> |
|--|------------------------------------|--|---------------------------------|

|   |   |                                   |  |
|---|---|-----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br><u>See. Yes.</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of liver</u>   |                                   |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |                                   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>cerebral apoplexy</u><br><u>generalized arteriosclerosis</u>                        |   | <u>2 1/2 hrs</u><br><u>years.</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) <u>1561</u> |
|--|--|---|

|  |  |                                  |
|--|--|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____ | 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 1948 to Sept 2, 1954, that I last saw the deceased alive on Sept 1, 1954, and that death occurred at 3:40A m., from the causes and on the date stated above.

|                                   |                               |                                      |                                |
|-----------------------------------|-------------------------------|--------------------------------------|--------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> | (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>Springfield, Mo.</u> | 23c. DATE SIGNED <u>9-4-54</u> |
|-----------------------------------|-------------------------------|--------------------------------------|--------------------------------|

|   |                               |   |  |
|---|-------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Sept 3, 1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u> |
|---|-------------------------------|---|--|

|  |  |  |                                 |
|--|--|--|---------------------------------|
| DATE REC'D BY LOCAL REG. <u>9-4-54</u> | REGISTRAR'S SIGNATURE <u>[Signature]</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeizer, Springfield, Mo.</u> | ADDRESS <u>Springfield, Mo.</u> |
|--|--|--|---------------------------------|

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

No. 300  
10-48  
390

SEP 10

SEP 9

JAN 22 1958

**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.....  
Signature of Student Embalmer

Signed *Robert E. Muhlman*

Licensed Embalmer No. *491*

P. O. Address *Springfield*

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.