

pt. Health,  
, & Welfare  
S. Public  
lth Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39667

STATE FILE NUMBER

FILED NOV 26 1957

Registration District No. 74 Primary Registration District No. 5295 Registrar's No. 58

S. 300  
ev. 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Plattsburg-Concord</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Trimble</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lewis Rest Home</b>		Length of stay in lb <b>3 Months</b>	d. STREET ADDRESS (If outside, give location) <b>None</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Wallace</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>13,</b> Year <b>1957</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1886</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>22</b>
IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Clinton Co., Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>John Lee Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Eads</b>		14. NAME OF HUSBAND OR WIFE <b>Cora Berry Brown</b>	
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>496-26-1142</b>	17. INFORMANT <b>Robert B. Brown</b> Address <b>Trimble, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Hypertensive-arteriosclerotic heart disease 6 yrs</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>6+ yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6+ yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pernicious Anemia</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>1951</b> to <b>Nov. 13, 1957</b> and last saw him alive on <b>Nov. 12, 1957</b> Death occurred at <b>5 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>F. Luckenbill MD</b> (Degree or title)		22b. ADDRESS <b>Plattsburg, Mo.</b>		22c. DATE SIGNED <b>15 Nov, 1957</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-15-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Clinton County, Missouri</b>		
24. FUNERAL DIRECTOR <b>McComas Funeral Home</b> ADDRESS <b>Smithville, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 15, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Elizabeth Avarace</b>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 .....  
Signature of Student Embalmer

Signed *Donald W. Hanks* .....

Licensed Embalmer No. ....  
P. O. Address .....

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.