

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011014

STATE FILE NUMBER

FILED APR 7 1958

Registration District No.

278

Primary Registration District No.

2054

Registrar's No.

60

300  
-57  
0  
210

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u> (10821)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP.</u>		Length of stay in 1b <u>15 1/2 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>2004 SO. CAROLINA</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILLARD ISAAC BROWN</u>			4. DATE OF DEATH Month Day Year <u>MARCH 26, 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28, 1902</u>	9. AGE (In years) (If UNDER 1 YEAR, IF UNDER 24 HRS.) Months Days Hours Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done with regularity or periodically, if retired) <u>PHARMACIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG STORE</u>		11. BIRTHPLACE (City and state or country) <u>MILAN, MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>CHARLES W. BROWN</u>		13b. MOTHER'S MAIDEN NAME <u>AGNES ISAACS</u>	
14. NAME OF HUSBAND OR WIFE <u>NORA FRANCES BROWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-34-859</u>	
17. INFORMANT Address <u>MRS. M. I. BROWN, LOUISIANA, MO.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Uremia from Toxemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Post Cholecystectomy and common duct drainage</u> date of surgery: <u>3/5/58</u> DUE TO (c) <u>Probable Carcinoma at head of pancreas</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 Month, Day, Year a.m. 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 <u>2/17/58</u> to <u>3/26/58</u> and last saw her alive on <u>3/25/58</u> Death occurred at <u>6:35 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Bernice Collier</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Louisiana, Mo.</u>		22c. DATE SIGNED <u>3/31/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>BURIAL MARCH 28, 58</u>		<u>MARCH 28, 58</u>	<u>RIVERVIEW CEM.</u>		<u>LOUISIANA, MO.</u>
24. FUNERAL DIRECTOR <u>GEO. M. COLLIER, LOUISIANA, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>MARCH 31, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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JUL 3 1958

OCT 20 1958

NOV 15 1958

MAY 1 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 *Geo S. Callier*

Licensed Embalmer No. *3839*

P. O. Address *Louisiana*

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.