

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008185

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		c. CITY OR TOWN <u>Goodman Mo</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>P.O. 1</u>	
Length of stay in 1b <u>3 1/2 28 1/2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM KIRBY BROWN</u>			4. DATE OF DEATH Month Day Year <u>2 8 1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</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>8-7-1887</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	

13a. FATHER'S NAME <u>James C. Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Georgia A. Carter</u>		14. NAME OF HUSBAND OR WIFE <u>Gertrude Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>430-05-8627</u>	17. INFORMANT Address <u>Hospital records</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>Cerebrovascular accident.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u> <u>Years</u>
DUE TO (b) <u>arteriosclerosis</u>		
DUE TO (c) _____		
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 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 3/1/1956 to 2/8/1959 and last saw ^{her} ~~him~~ alive on 2/8/1959
Death occurred at 6:19 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.C. Bradley M.D.</u> (Deceased or title)	22b. ADDRESS <u>State Hospital #3 Newbern Mo.</u>	22c. DATE SIGNED <u>2/8/1959</u>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	23b. DATE <u>2-8-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Howard Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Goodman, Missouri</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR <u>Carl Rapp Anderson, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-11-1959</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Gerry</u>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

300
-57 2

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Carl Papp*

Licensed Embalmer No. *03458*
P. O. Address *Anderson, Y*

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.