

Dept. Health,  
J. S. Public  
Health Service

FILED VS AUG 25 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-021219  
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 322

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Marion</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Marion</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</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>86 Millers rest Home</b>		Length of stay in lb <b>40yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>0649-702 Lemon</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Addie Clay Brown</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>13</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-21-81</b>	9. AGE (In years, <sup>179</sup> birthday) <b>79</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>New London Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>William Braxton</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Prime 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>none</b>		17. INFORMANT Address <b>Minnie Miller 702 lemon Hannibal</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					<b>332X</b>
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? <b>2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>
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 _____ a.m. _____ p.m. Month, Day, Year _____					
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>8/1/60</b> to <b>8/13/60</b> and last saw her alive on <b>8/13/60</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> (Degree or title)			22b. ADDRESS <b>Hannibal Mo.</b>		22c. DATE SIGNED <b>Aug 15 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8-16-60.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Robinson Cemetery</b>		23d. LOCATION (City, town, or county) <b>Hannibal Mo.</b>
24. FUNERAL DIRECTOR <b>W.R. Sephus</b> ADDRESS <b>Hannibal Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>8/16/60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

*M. Herman*

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 *H. R. Stephens* .....

Licensed Embalmer No. *3420*

P. O. Address *Hannibal Mo*

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.