URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 16 1961

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STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 2

ENDED

1. PLACE OF DEATH
a. COUNTY: Macon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Macon
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Samaritan Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Macon
c. CITY OR TOWN: Macon
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 215 Washington
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First HUBERT Middle GREEN Last BROWN

4. DATE OF DEATH: Month Dec. Day 19 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/18/1888
9. AGE (last birthday): 72
IF UNDER 1 YEAR / IF UNDER 24 HR: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: City Govt.
11. BIRTHPLACE (City and state or country): Macon County Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William G. Brown
13b. MOTHER'S MAIDEN NAME: Rosa Lunsford
14. NAME OF HUSBAND OR WIFE: Lillian Marsh Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Lillian Brown Address: Macon, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Myocarditis c. Decompensation — 2 mos.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Severe Secondary Anemia (Cause Unknown)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 June 1958 to Dec. 19-1960 and last saw her/him alive on Dec 19-1960
Death occurred at 11 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Howard Mueller MD
22b. ADDRESS: Macon
22c. DATE SIGNED: 1/3/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-21-1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. Salem
23d. LOCATION (City, town, or county) (State): Excello Mo.

24. FUNERAL DIRECTOR: R. Lester Brown ADDRESS: Macon, Mo.
25. DATE RECD. BY LOCAL REG.: 1-6-61
26. REGISTRAR'S SIGNATURE: Lulu McNeely

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed R. Foster Brown

Signature of Student Embalmer

Licensed Embalmer No. 4472

P. O. Address Macon, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.