

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032317

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8510**

FILED SEP 10 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS COUNTY</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>ARKANSAS</b><br>b. COUNTY <b>RAVENDEN</b>              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MISSOURI</b>  |   | Length of stay in 1b  | c. CITY OR TOWN <b>RAVENDEN</b><br>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>FRISCO HOSPITAL</b><br><b>FRISCO HOSPITAL</b>   |   | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <b>GENERAL DELIVERY</b><br>Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                     |
| 3. NAME OF DECEASED (Type or print) <b>ANDREW A. BROWN</b><br>First <b>ANDREW</b> Middle <b>A.</b> Last <b>BROWN</b>   |   | 4. DATE OF DEATH <b>SEPT 15 1962</b><br>Month <b>SEPT</b> Day <b>15</b> Year <b>1962</b>  |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>WHITE</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>9-21-1905</b><br>9. AGE (last birthday) <b>56</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>   | 11. BIRTHPLACE (City and state or country) <b>OVERLAND TENNESSEE</b><br>12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |
| 13a. FATHER'S NAME <b>ALVIN BROWN</b>  |   | 13b. MOTHER'S MAIDEN NAME <b>ETHEL SPRAGG</b>   | 14. NAME OF HUSBAND OR WIFE <b>NOLA</b>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>   |   | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b>  | 17. INFORMANT Address <b>MRS. NOLA BROWN RAVENDEN, ARK.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b><br>DUE TO (b) _____<br>DUE TO (c) <b>163X</b>                                 |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>26 DAYS</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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 _____ a.m. _____ p.m. Month, Day, Year _____  | 20d. INJURY OCCURRED WHILE AT WORK <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>AWAITING 1962 SEPT 1 1962</b> and last saw him alive on <b>SEPT 15 1962</b><br>Death occurred at <b>2:20 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title) <b>[Signature]</b>  |   | 22b. ADDRESS <b>FRISCO HOSPITAL</b>   | 22c. DATE SIGNED <b>9/1/62</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE <b>9-4-62</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>BRADFORD CEMETERY</b>   | 23d. LOCATION (City, town, or county) (State) <b>near RAVENDEN, ARK.</b>   |
| 24. FUNERAL DIRECTOR <b>MC NABB FUNERAL HOME</b>   |   | 25. DATE RECD. BY LOCAL REG. <b>SEP 4 1962</b>  | 26. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |

OCT 2 1962

NOV 2 1962

MAR 1 1963

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

*Severey R. Pollette*

Licensed Embalmer No.

3481

P. O. Address

*Crystal City, 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.