

OCT 24 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26391

1. PLACE OF DEATH

County Andrew
Township Recheater
City Holt (No. _____)

Registration District No. 16
Primary Registration District No. 5020

File No. _____
Registered No. 12 (St. _____ Ward)

2. FULL NAME

Sarah Ann Brown

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

John W. Brown

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb. 16 -

7. AGE

YEARS
79

MONTHS

6

DAYS

29

IF LESS than 1
day, hrs. _____
or min. _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

10. NAME OF FATHER

James Hampton

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Cynthia Williamson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

14. INFORMANT

(Address)

A. E. Brown
Holt, Mo

15. FILED

Sept 16 1927

Ms. Bettie Rose
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Sept 15 1927

17.

I HEREBY CERTIFY, That I attended deceased from March 29, 1926, to Sept 15, 1927, and that I last saw him alive on Sept 15, 1927, and that death occurred, on the date stated above, at 8:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Emphysema of the lungs
77 / 12261
(duration) / yrs. 6 mos. ds.

CONTRIBUTORY

(SECONDARY)
Arteriosclerosis (duration) / yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

Sept 16 (Signed) Chas. L. Allen, M. D.
(Address) Barry Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Union Chapel Cemetery 9/17 1927

20. UNDERTAKER

ADDRESS

H. L. Wilson King City

1

1

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Andrew
Township..... Rochester
City..... Sarah Ann Brown (No., St. Ward)

Registration District No. 16
Primary Registration District No. 3820

File No.
Registered No. 17

2. FULL NAME Sarah Ann Brown

(a) Residence, No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 16 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Sept 16 27 Mrs. Bettie Boyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1927

17. I HEREBY CERTIFY, That I attended deceased from to that I last saw h..... alive on and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state information should be supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. May be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L.

1A: 98-S