

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

27993

PLACE OF DEATH
County Knox

Township _____
or
Village _____
or
City Edina (NO. _____)

Registration District No. 441

File No. _____

Primary Registration District No. 457

Registered No. 14

FULL NAME Freddie Brown

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH July 14 - 1895
(Month) (Day) (Year)

AGE 20 yrs. 1 mos. 2 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Edina Mo.

PARENTS
NAME OF FATHER Melven Brown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Edina Mo.
MAIDEN NAME OF MOTHER Maggie Blood
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Chicago

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Wm. M. Mendenhall

(ADDRESS) Edina Mo.
Filed Sept 10, 1915 H. J. Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 15th, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 15th, 1915, to Aug 15th, 1915, that I last saw him alive on Aug 15th, 1915, and that death occurred, on the date stated above, at 7⁰⁰ p.m.

The CAUSE OF DEATH* was as follows:

Enteritis
120 B
105
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
8 (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. A. Campbell M. D.
Aug 16, 1915 (Address) Edina Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence Edina

PLACE OF BURIAL OR REMOVAL Linnville Cemetery DATE OF BURIAL Aug 16, 1915

UNDERTAKER Kriegshauser Bros ADDRESS Edina Mo.

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

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE
		MARRIED
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	WIDOWED
		OR DIVORCED
AGE	(Month) _____ (Day) _____ (Year) _____	(If ride the ward)

DATE OF BIRTH

AGE _____ (Month) _____ (Day) _____ (Year) _____

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

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

(City or town, State or foreign country)

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

(City or town, State or foreign country)

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

PARENTS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed _____, 191____, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

DATE OF BURIAL

ADDRESS

PLACE OF BURIAL OR REMOVAL

UNDERTAKER

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____
