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

28561

PLACE OF DEATH

County: Marion

Township: Union
or
Village:
or
City: (NO. St.; Ward)

Registration District No.: 549 File No.:

Primary Registration District No.: 5747 Registered No.:

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

FULL NAME Unnamed Brown

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

DATE OF BIRTH: July (Month) 6 (Day), 1916 (Year)

AGE: yrs. mos. 10 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Philadelphia Mo

PARENTS
NAME OF FATHER: Frank A. Brown
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill
MAIDEN NAME OF MOTHER: Cynthia Gibson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Marion Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): F. A. Brown
(ADDRESS): Philadelphia

Filed Aug 2, 1916. C. F. Triplett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 15 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July 11, 1916, to July 15, 1916, that I last saw h[illegible] alive on July 15, 1916, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Ulcerative stomatitis
11513
99
(Duration) yrs. mos. 5 ds.

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

(Signed) C W Hamlin M. D.
July 16, 1916 (Address) Philadelphia

*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

PLACE OF BURIAL OR REMOVAL: Phila Mo.
DATE OF BURIAL: July 16 1916
UNDERTAKER: B. M. Allen
ADDRESS: Phila Mo

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.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO. ..... St.; ..... Ward)

[If death occurred in hospital or institutio give its NAME inste of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or ....min.?

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)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

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(Month) (Day) (Yea

I HEREBY CERTIFY, that I attended deceased fr

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that I last saw h.....alive on....., 191...

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

The CAUSE OF DEATH* was as follows:

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.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed)..... M.

....., 191.... (Address).....

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

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

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
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UNDERTAKER	ADDRESS

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