WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF DEATH

County Knox

Township Greensburg or Village ____ or City ____ (NO. ____, ____ St.; ____ Ward)

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

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

Registration District No. 439 File No. 19091

Primary Registration District No. 5596 Registered No. 60

FULL NAME David Brown

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

DATE OF BIRTH: August (Month) 19 (Day), 1839 (Year)

AGE: 78 yrs. 7 mos. 9 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS
- NAME OF FATHER: John Brown
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia
- MAIDEN NAME OF MOTHER: Mary Middleton
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. O. Brown

(ADDRESS) Boring Mo.

Filed May 23 1917 Geo. Wrecker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 22 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from May 16, 1917, to May 21, 1917, that I last saw h[illegible] alive on May 21, 1917, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

1 wk

(Duration) ____ yrs. ____ mos. 6 ds.

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

(Signed) W. E. Lucas M. D.

May 22, 1917 (Address) Baring 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 ____

PLACE OF BURIAL OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: May 23 1917

UNDERTAKER: Kreyslane Bros — ADDRESS: Edina Mo.

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

PLACE OF DEATH

County.....

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

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

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

[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, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day) 1..... (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

.....(Month) .....(Day) 191..... (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:

.....

.....

.....

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

Contributory (SECONDARY).....

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

(Signed)..... M. D.

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

*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	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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