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

PLACE OF DEATH

County: Barton

Township: _____ or Village: _____ or City: Lamar (NO. _____ St.: _____ Ward)

Registration District No. 40

Primary Registration District No. 4024

File No. 27693

Registered No. 36

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

FULL NAME Henry Brown

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Wht

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

DATE OF BIRTH: 3 (Month) 17 (Day) 1857 (Year)

AGE: 64 yrs. 5 mos. 8 ds. If LESS than 1 day: ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER: Kimsley Brown
BIRTHPLACE OF FATHER (City or town, State or foreign country): Vermont
MAIDEN NAME OF MOTHER: Nimiva Gardner
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Vermont

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Felix Brown

(ADDRESS) Lamar Missouri

Filed Aug 27, 1917. Hoyt X Humphrey by _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug 25th, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1917, to Aug 25, 1917, that I last saw him alive on Aug 25, 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(Duration) 2 yrs. 2 mos. — ds.

Contributory (SECONDARY) Locomotor Ataxia

(Duration) 8 yrs. — mos. — ds.

(Signed) F. D. Allen M. D.

Aug 26, 1917 (Address) Lamar 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: Lamar Hope Cemetery

DATE OF BURIAL: Aug. 27. 1917

UNDERTAKER: Hoyt X Humphrey

ADDRESS: Lamar Mo

WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT.

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

PLACE OF DEATH

County .....

Township ..... or

Village ..... or

City .....

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

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

(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 WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ....., *1*..... (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

..... (Month) ....., *191*..... (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:

.....

.....

.....(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