LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 43814

1 PLACE OF DEATH

County: Shelby

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

Registration District No. 827 File No. .....

Primary Registration District No. 4560 Registered No. 70

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

2 FULL NAME: Thomas Island Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: July 8 (Month) (Day), 1882 (Year)

7 AGE: 36 yrs. 4 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Edwin James Brown

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Pa. Sevier

12 MAIDEN NAME OF MOTHER: Amelia Vanlippe

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Doctor Brown

(Address) Clarence Mo

15 Filed Nov. 19, 1918 W. M. Bayliss Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 15 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 12, 1918, to Nov 15, 1918, that I last saw him alive on Nov 15, 1918, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

11A

10

108

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

CONTRIBUTORY (Secondary) Pa Grippe

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

(Signed) Dr. Harris M. D.

Nov 19, 1918 (Address) Clarence Mo.

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL: Edina Mo. DATE OF BURIAL: 11-18-1918

20 UNDERTAKER: E. E. Hopper ADDRESS: Clarence Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE 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 a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE ..... yrs. ..... mos. ..... ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS