

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

1 PLACE OF DEATH

County Stone
Township Polace
or
Village
or
City Crane (NO. St. Ward)

Registration District No. 842
Primary Registration District No. 4872

File No. 18887
Registered No.

2 FULL NAME

Lester M Browning

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>May</u> <u>7</u> <u>1887</u> (Month) (Day) (Year)		
7 AGE <u>32</u> yrs. <u>17</u> mos. <u>17</u> ds.		8 If LESS than 1 day, hrs. or min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>By mail clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Verona Mo</u>		
PARENTS	10 NAME OF FATHER <u>H M Browning</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tenn</u>	
	12 MAIDEN NAME OF MOTHER <u>Emma Kenney</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L M Browning
Crane

(Address)

15

June 1 1919 Russell

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>May</u> <u>24</u> <u>1919</u> (Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from <u>4-29</u> , 191 <u>9</u> , to <u>5-24</u> , 191 <u>9</u> , that I last saw him alive on <u>5-23</u> , 191 <u>9</u> , and that death occurred, on the date stated above, at <u>8:30 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> <u>11 A</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. CONTRIBUTORY <u>Spanish Flu</u> (Secondary) (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. (Signed) <u>JCR Duggitt</u> M. D. <u>5-24</u> , 191 <u>9</u> (Address) <u>Crane Mo</u>

*State the Disease Causing Death, or, in death 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 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.
Where was disease contracted if not at place of death? St Louis Mo
Former or usual residence Verona Mo

19 PLACE OF BURIAL OR REMOVAL

Verona Mo

DATE OF BURIAL

5-25, 1919

20 UNDERTAKER

W E Helton

ADDRESS

Crane Mo

1 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.]

2 FULL NAME

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)

(Year)

7 AGE

If LESS than
1 day

1 day

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)

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

12 MAIDEN NAME
OF MOTHER13 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

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH

(Month)

(Day)

(Year)

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that I last saw him alive on, 191

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

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed)

....., 191 (Address)

M. D.

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At place

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Where was disease contracted

If not at place of death?

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19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191

20 UNDERTAKER

ADDRESS