JAN 23 1929

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

Do not use this space.

41226

1. PLACE OF DEATH

County: Jackson — Registration District No.: 400 — File No.:

Township: Prairie — Primary Registration District No.: 2553B — Registered No.: 157

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME Quinton Browning

(a) Residence. No. Jackson Co. Home St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 12 1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	58	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Thomas Browning

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Un Know

12. MAIDEN NAME OF MOTHER Un Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Un Know

14. INFORMANT J. W. Hostetter
(Address) Sept Jackson Co. Home

15. FILED 12/7, 1928 F. M. Schick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-7-1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1928, to December 6, 1928 that I last saw him alive on December 6, 1928, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
93C 90B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) General inanition
(duration) ..... yrs. 3 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. W. Greene, M. D.
12/8, 1928 (Address) Independence Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Blue Springs — DATE OF BURIAL: 12-9 1928

20. UNDERTAKER: G B Webb — ADDRESS: Blue Springs Mo

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.

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