

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

Do not use this space.

21315

1. PLACE OF DEATH  
 County Howard Registration District No. 387  
 Township \_\_\_\_\_ Primary Registration District No. H-277  
 City West Plains St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Joseph Brown  
 (a) Residence No. \_\_\_\_\_ 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 FW 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 15 - 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
49 4 28

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

9. BIRTHPLACE (CITY OR TOWN) Howard Co. Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Joe Campbell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn.  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Farrer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.  
 (STATE OR COUNTRY)

14. INFORMANT John Brown  
 (Address) West Plains Mo.

15. FILED 6-18-1929 O. P. A. Heinrich REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/13 - 1929  
 17. I HEREBY CERTIFY, That I attended deceased from 5-1  
 1929 to 6-13-1929, 1929  
 that I last saw him alive on 6-11-30 1929 and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Regurgitation  
3H  
72A

CONTRIBUTORY (SECONDARY) Lues (duration) yrs. mos. ds.  
 18. WHERE WAS DISEASE CONTRACTED Home  
 IF NOT AT PLACE OF DEATH?  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Radiogram  
 (Signed) \_\_\_\_\_ M. D.  
6-18-1929 (Address) West Plains 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 Sadie Brown DATE OF BURIAL 6-16-1929

20. UNDERTAKER W. C. Farland ADDRESS West Plains

46  
 25  
 1929  
 4  
 4  
 238  
 1  
 2  
 2  
 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

