

MISSOURI STATE BOARD OF HEALTH

Do not use this space.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

27450

1. PLACE OF DEATH

County Greene Registration District No. 316 File No. 563
 Township Springfield Precinct Registration District No. 2086 Registered No. 563
 City Springfield (No. Springfield Hospital) St. Springfield Ward

2. FULL NAME

John A. Brown
 (e) Residence. No. Standard No. Ward. Standard No.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED: HUSBAND OF (OR) WIFE OF Margaret D. Diller

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 / 1 / 2

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

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

10. NAME OF FATHER Am Brown

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

12. MAIDEN NAME OF MOTHER Tha Blandford

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

14. INFORMANT Geo. Brown
 (Address) Standard Mo.

15. FILED 10-3 1929 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-3-29

17. I HEREBY CERTIFY That I attended deceased from July 28, 1929, to July 29, 1929, that I last saw him alive on 8-3-29, and that death occurred, on the date stated above, at 10 am.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial infarction subsequent to Arteriosclerotic hypertrophy
137 (duration) yrs. mos. da.

19. CONTRIBUTORY (SECONDARY) 135 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

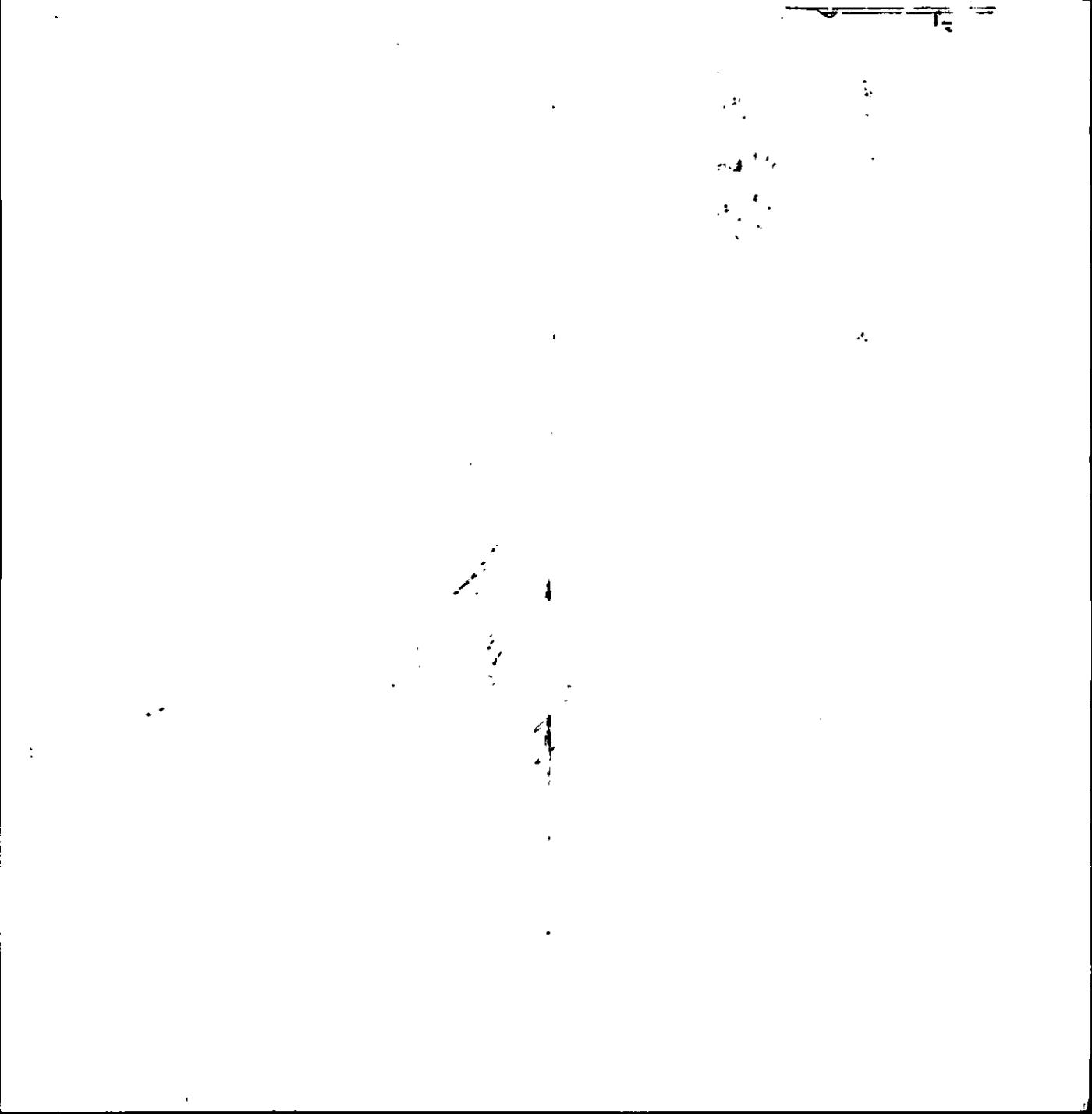
20. DID AN OPERATION PRECEDE DEATH? no DATE OF no
 WAS THERE AN AUTOPSY? no

21. WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) James E. Dewey, M.D.
135 Springfield 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 Greene Mo. DATE OF BURIAL 8-4-29

20. UNDERTAKER W. H. Lane ADDRESS Standard Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. _____

Township _____

Primary Registration District No. 2001

Registered No. 363

City Springfield (No. _____)

St. _____ Ward _____

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1 - 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
60 1 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. _____ (duration) _____ yrs. _____ mos. _____ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

15. FILED 8-3-22 Gov Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 3 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

_____, 19____ (Address)

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-27450