

31380-1

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

Do not use this space.

U31380

PLACE OF DEATH

County... *Miller*
Township... *Emulation*
City... (No.) St. Ward)

Registration District No. *364*
Primary Registration District No. *3258*

File No.
Registered No.

2. FULL NAME *Geo W 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. 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 *Carilda Brown*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *12-24-1860*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *62 7 28*

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

9. BIRTHPLACE (CITY OR TOWN) *Monstace*
(STATE OR COUNTRY) *MO*

10. NAME OF FATHER *Shirley Brown*

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

12. MAIDEN NAME OF MOTHER *Eliza Anglin*

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

14. INFORMANT *CC Brown*
(Address) *Lusambi MO*

15. FILED *3/22/19*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-22-19*
17. I HEREBY CERTIFY That I attended deceased from *5-2-19* to *5-2-19*, 19*19* that I last saw him alive on *5-2-19*, 19*19*, and that death occurred, on the date stated above at *10:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart failure right side

CONTRIBUTORY (SECONDARY) *10*
(duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? *NO* DATE OF

WAS THERE AN AUTOPSY? *NO*

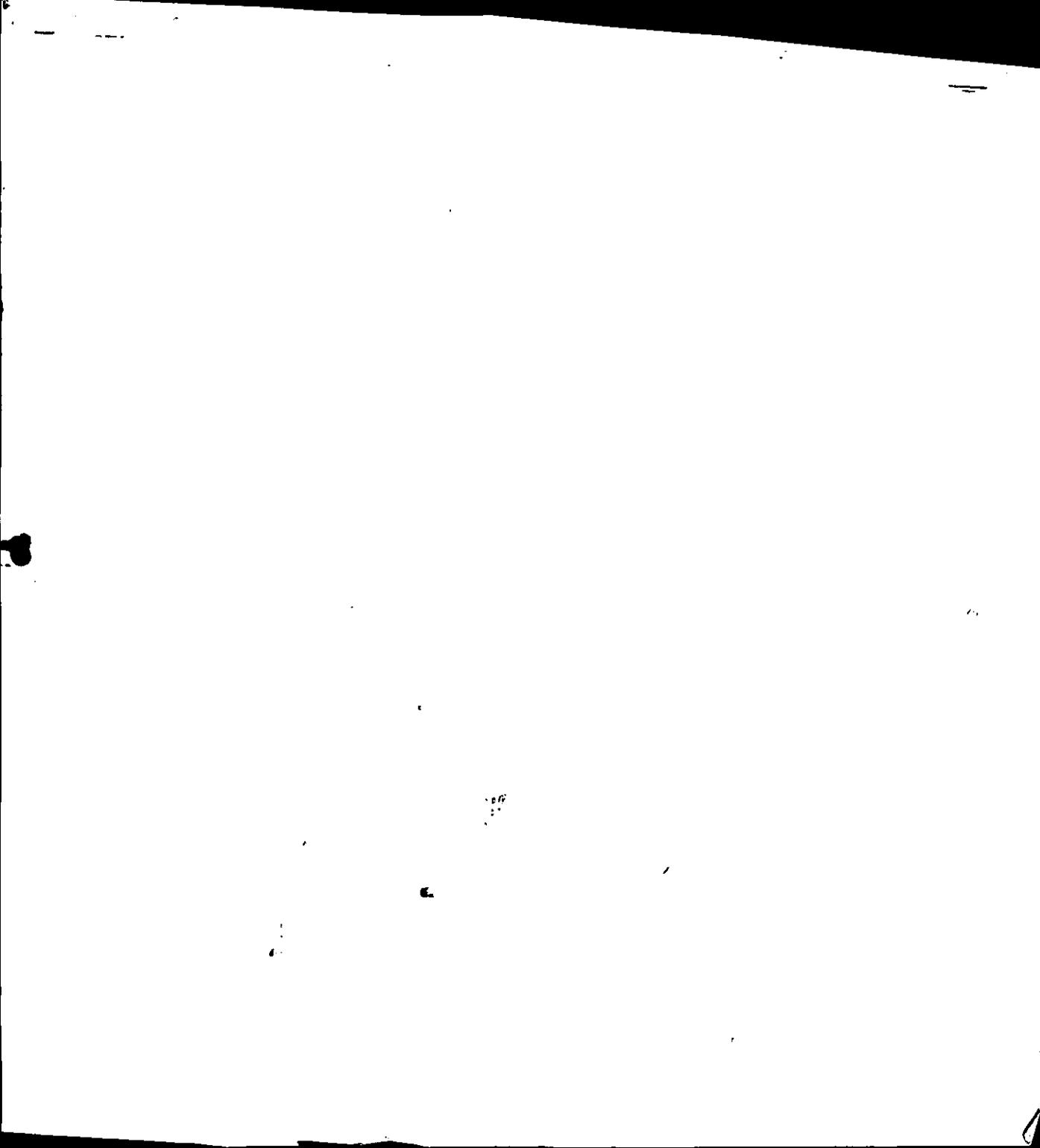
WHAT TEST CONFIRMED DIAGNOSIS *Synaphone*
(Signed) *ATK*, M. D.
, 19 (Address) *Lusambi*

*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 *Lusambi MO* DATE OF BURIAL *3/24 1919*

20. UNDERTAKER *W A Phelps* ADDRESS *3-22-19*

AGE should be stated EXACTLY. PHYSICIAN should state EXACTLY. Exact statement of OCCUPATION is important. AGE should be properly classified.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Madison Registration District No. 564 File No.
 Township Equality Primary Registration District No. 3758 Registered No.
 City (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)

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

8. OCCUPATION OF DECEASED

(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)

(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 9-25 19 29

W. H. Row
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/22 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)

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

19

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

ARTS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-31380A