

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

Do not use this space.

17159

85

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph

Registration District No. _____
Primary Registration District No. 1001
(No. Missouri Methodist Hospital)

File No. _____
Registered No. 500
St. _____ Ward)

2. FULL NAME Frank S Brownlee

(a) Residence. No. 2018 Felix street St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
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6. ~~MARRIED, WIDOWED, OR DIVORCED~~
HUSBAND OF Emma Brownlee
(OR) WIFE OF

7. DATE OF BIRTH (MONTH, DAY AND YEAR) October 12, 1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>68</u>	<u>6</u>	<u>26</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Barber
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer Self

*131
922
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9. BIRTHPLACE (CITY OR TOWN) Holt Co.
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Robert Brownlee

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lewis Co.
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Rachel Forker

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

14. INFORMANT Walter Brownlee
(Address) Waverly Hotel-Lincoln Nebr.

15. John R Bender
REGISTRAR

FILED 9 1931
MAY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1931

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to May 8, 1931 that I last saw him alive on May 7, 1931, and that death occurred, on the date stated above, at 6/45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Stenosis of Heart
& cardiac decompensation

CONTRIBUTORY (SECONDARY) Chronic Endocarditis
Chronic nephritis (duration) 6 yrs. 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? Phys. Exam
(Signed) J. H. Thompson, M. D.

May 9 1931 (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 <u>Mt. Mora Cemetery</u>	DATE OF BURIAL <u>May 9 19 31</u>
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20. UNDERTAKER <u>H. O. Sidenfaden</u>	ADDRESS <u>1802 Union st.</u>
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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.

JUN 24 1931

