

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

Do not use this space.

39716

JAN 26 1934
3

PLACE OF DEATH *Green*
 County *Green* Registration District No. *318*
 Township *Springfield* Primary Registration District No. *2001*
 City *St. John's Home* St. *St. John's Home* Ward *St. John's Home*
 2. FULL NAME *Wm. Chas. Brown*
 (a) Residence, No. *Lebanon, Mo.* Ward. *Lebanon, Mo.*
 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. (If nonresident, give city or town and State)

File No. *39716*
 Registered No. *843*
 St. *St. John's Home* Ward *St. John's Home*

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 *Katherine Brown*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 7 1870*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *63 10 23*
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Machinist*
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*
 FATHER 13. NAME *Walter E. Brown*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*
 MOTHER 15. MAIDEN NAME *Fannie Mathie*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*
 17. INFORMANT (ADDRESS) *Harrie Wallick Lebanon Mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Lebanon* DATE *Dec 3 1933*
 19. UNDERTAKER (ADDRESS) *W. E. Holman Lebanon Mo*
 20. FILED *12-1* 19*33* *Ralph W. Langston Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 1 1933*
 22. I HEREBY CERTIFY, That I attended deceased from *Nov. 30 1933* to *Dec 1 1933*
 I last saw him alive on *Nov. 30 1933* Death is said to have occurred on the date stated above, at *9:19 a.m.*
 The principal cause of death and related causes of importance were as follows:
Septicemia (Staphylococcus) Date of onset *9/15/33*
 Other contributory causes of importance *(Primary infection not located)*
 Name of operation *3/4*
 What test confirmed diagnosis? *Blood culture* Date of *3/4*
 Was there an autopsy? *No*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *No* Date of injury *19*
 Where did injury occur? *No injury found*
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *?*
 Nature of injury *?*
 24. Was disease or injury in any way related to occupation of deceased? *No*
 If so, specify
 (Signed) *J. B. Holman*, M. D.
 (Address) *SPRINGFIELD Mo*

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

