

NOV 18 1937

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

Do not use this space.

36637

1. PLACE OF DEATH

County Jackson
Township Law
City J. C. Mo. (No. General Hospital)

Registration District No.
Primary Registration District No.

File No.
Registered No. 4066
St. 22 Ward

2. FULL NAME

Basie Brownfield
(a) Residence, No. 5329 So Benton 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 Female
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unk 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 60

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

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) Miss.

13. NAME Unclear

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unclear

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Record Clerk Central Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE Oct. 24, 1937

19. UNDERTAKER (ADDRESS) C. Stebbins Bell

20. FILED Oct 11 1937 M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-29 1937

22. I HEREBY CERTIFY, That I attended deceased from 8-18 1937 to 9-29 1937

I last saw her alive on 9-29 1937 Death is said to have occurred on the date stated above, at 8:15 A.M.

The principal cause of death and related causes of importance were as follows:

Pau - ophthalmitis (Post-Operative)
Date of onset

Other contributory causes of importance:

Typhemia

Name of operation Date of
What test confirmed diagnosis Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (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. Brown M. D. (Address) General Hosp #2

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

[Handwritten marks and scribbles]

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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36637
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No.
(b) Township Primary Registration District No. Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rosie Brownfield

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W
(write the word)

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.
apt 60

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 29 1937

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the day stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Post-operative
Phalmitis

Date of onset

ULCER OF CORNEA

Other contributory causes of importance:

Toxemia 88

ENUCLEATION OF EYE Date of 9/10/37

Name of operation What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (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?

If so, specify

(Signed) P.C. Turner , M. D.

(Address) Gen Hosp # 2

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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