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.

REC'D APR 11 1939

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

10411
Do not use this space.

1. PLACE OF DEATH
(a) County Carter — Registration District No. 146
(b) Township Pike — Primary Registration District No. 5209 — Registered No. 29
(c) City or Town Fremont — (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 1 yrs. 50 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John M. Brown
(a) Residence, No. ____ St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 16-1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	68		16	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Mo

FATHER
13. NAME John M Brown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER
15. MAIDEN NAME Nancy Childwood
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) J. F. Brown Note Ark

18. BURIAL, CREMATION, OR REMOVAL
PLACE Ellington Mo DATE 3-14-39

19. FUNERAL DIRECTOR (NAME) Nunn
(ADDRESS)

20. FILED April 10, 1939 Jessie D. Schaefer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 12 - 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1939, to Mar 12-, 1939
I last saw him alive on Mar 12-, 1939. Death is said to have occurred on the date stated above, at 9 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cystitis + Prostatitis	

Other contributory causes of importance:

Name of operation ____ Date of ____
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) Frank Hogdell, M. D.
(Address) Ellington Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.