

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.

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

REC'D AUG 7 1939

25661
 Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 32
Franklin
 (b) Township SPRINGFIELD Primary Registration District No. 5446
 or FAIR GROVE MO R.F.D. #2 Registered No. 11
 (c) City SPRINGFIELD (d) Street No. MO R.F.D. #2 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 THOMAS MANNING BROWN

(a) Residence, No. AVA MO. R#1 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 24-1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>74</u>	<u>3</u>	<u>16</u>	

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. ON FARM
 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) PENNA.

FATHER 13. NAME THOMAS BROWN
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

MOTHER 15. MAIDEN NAME MARGARET
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) ETTA BROWN
AVA MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Comfort DATE July 12, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. KLINGNER & CO.
SPRINGFIELD MO.

20. FILED Aug 1 1939 Allan Barnes
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1939 to 1939

I last saw him alive on July 20, 1939. Death is said to have occurred on the date stated above, at 8:00 P. m.

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

Date of onset Aug 1

Other contributory causes of importance:
Senility

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? 76

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) J. Ferguson Cooper M. D.
 (Address) 604 E Elm

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 comply with the above constitutes grounds for revocation of license.)

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