

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

27120  
Do not use this space.

AUG 7 1939

1. PLACE OF DEATH *Vernon 3*

(a) County *Vernon* Registration District No. *875*

(b) Township *Wasson* Primary Registration District No. *62*

(c) City *Howard* (d) Street No. *State Hoop # 3* Registered No. *171*

(e) Length of residence in city or town where death occurred (If death occurred in Hospital or Institution, write its name instead of street and number) St.

2. PRINT FULL NAME *James M. Brown*

(a) Residence, No. *Springfield* 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 *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 *Anna Craig*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar 9 '62*

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

*77 4 7*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Laborer*

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) *DK*

11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

13. NAME *James M. Brown*

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

15. MAIDEN NAME *Sarah Shumate*

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

17. INFORMANT (ADDRESS) *Hosp. Records*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Springfield Mo* DATE *7/1/39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Alvan Johnson Springfield Mo*

20. FILED *July 17 1939 Allen V. Day* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 16 1939*

22. I HEREBY CERTIFY, That I attended deceased from *July 2 1939* to *July 16 1939*

I last saw him alive on *July 16 1939* Death is said to have occurred on the date stated above, at *10:05 pm*.

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

*Degenerative heart disease* Date of onset *DK*

*34*

Other contributory causes of importance: *Meningo Vascular Les DK*

*Heart*

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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..... *DK*

(Signed) *DK*, M. D.

(Address) *Nevada 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.

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1122

Date Filed 8-3-39

**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

*Raymond Rinkle*

Licensed Embalmer No. 3444

P. O. Address Springfield

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

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