

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.

Registration District No. 799

Primary Registration District No. 8037B

Registrar's No. 41

1. PLACE OF DEATH: 2
 (a) County Saline
 (b) City or town Gilliam (Camden)
 (c) Name of hospital or institution home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Luna Frances Brown 650
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex female
 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Bertha Brown
 6. (c) Age of husband or wife if alive 80 years
 7. Birth date of deceased 6/18/'66
 (Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 28
 If less than one day _____ hr. _____ min.

9. Birthplace Saline Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

MOTHER { 12. Name Jno. W. Duggins
 18. Birthplace Saline Co. Mo.
 14. Maiden name Artemus Hawkins
 15. Birthplace Saline Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Ollie Lee,
 (b) Address Gilliam, Mo.
 17. (a) burial (b) Date thereof 8/18/'39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Gilliam, Mo.

18. (a) Signature of funeral director Hill Brothers
 (b) Address Slater, Mo.
 19. (a) Aug 17 1939 (b) W. M. Tully
 (Date rec'd local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Saline
 (c) City or town Gilliam
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 8/16/'39 day _____
 year _____ hour 12 noon minute _____ M.
 21. I hereby certify that I attended the deceased from Sept-1938
 _____, 19____, to August-16- 1939;

that I last saw her alive on August-16- 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus. Duration 15 yrs.
 Due to _____
 Due to 59

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature M. C. Duggins (M.D. or other)
 Address Slater Mo Date signed 8/17/39

RECEIVED
District Health Officer No. 8,
District File Number
File Filled
9/12/39

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
Edgar Moore, Registered Apprentice No. 230
working under my personal supervision.

Signed A. C. Hill
Licensed Embalmer No. 3090
P. O. Address Slater, Mo.

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.