

No. 2  
1-10-39  
17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3376

Registration District No. 679

Primary Registration District No. 5907 (5907)

Registrar's No. 13

1. PLACE OF DEATH:  
(a) County: Sheep  
(b) City or town: Star Route  
(c) Name of hospital or institution: Rural - Cold Springs  
(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

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

3. (a) PRINT FULL NAME: Mary Annie Brown  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 23  
year 1940 hour 8 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 6-1  
\_\_\_\_\_ 1939, to 1-23, 1940

4. Sex: Female 5. Color or race: White  
6. (b) Name of husband or wife: Lee Brown  
7. Birth date of deceased: June 27 1859  
(Month) (Day) (Year)

that I last saw her alive on 1-22, 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Hypostatic pneumonia

8. AGE: Years 80 Months 6 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Senility  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace: Sheep Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation: Homemaker

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

MOTHER FATHER  
11. Industry or business: \_\_\_\_\_  
12. Name: Alfred Laemlein  
13. Birthplace: Don't know  
(City, town, or county) (State or foreign country)  
14. Maiden name: Don't know  
15. Birthplace: Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant: Marion Brown  
(b) Address: Sheep Mo

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof: Jan 24 1940  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation: Rural Cemetery

18. (a) Signature of funeral director: Rolla  
(b) Address: Rolla Mo

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury: \_\_\_\_\_  
23. Signature: E. F. Fink M.D. (M. D. or other)  
Address: Rolla, Mo. Date signed: 1-24-40

19. (a) Jan. 24, 1940 (b) Joe F. Ayers  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

District Health Officer No. 5,

District File Number 240 229

Date Filed 2-16-40

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.

Registration District No. **679**

Primary Registration District No. **5907**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County **Chelso**  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(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

**Marybrian Brown**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **80** Months **6** Days **28** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 **Jan** day **23** year **1946** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive pneumoema**

Due to **Senility**

**neither lobar nor bronchial, simple Description of base of both lungs in congested areas resulting from circulatory failure**

Major findings: Of operations \_\_\_\_\_

Of autopsy **111B**

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 **E E Fend** (M. D. or other) \_\_\_\_\_

Address **Pallas** Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-3376