

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

7587  
Do not use this space.

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

1. PLACE OF DEATH *W*  
 (a) County *Nodaway* Registration District No. *628*  
 (b) Township *Green* Primary Registration District No. *5370-5836*  
 (c) City *Quitman Mo.* (d) Street No. \_\_\_\_\_ (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 *4* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Daniel P. Brown*  
 (a) Residence, No. *Highway Quitman Mo Rural* (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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Divorced</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <i>Cora Brown</i> (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>2-17-1855</i>				
7. AGE	YEARS <i>84</i>	MONTHS <i>11</i>	DAYS <i>15</i>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>Farmer</i>			
	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) <i>Ill</i>				
FATHER	13. NAME <i>Milton Brown</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ky</i>			
MOTHER	15. MAIDEN NAME <i>Louisa Gray</i>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo</i>			
17. INFORMANT <i>Guy Oliver</i> (ADDRESS) <i>Lola Kansas</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Miriam Cem</i> DATE _____ 19____				
19. FUNERAL DIRECTOR (NAME) <i>Campbell Funeral</i> (ADDRESS) <i>Maryville Mo Home</i>				
20. FILED <i>Feb 5 - 1940</i> <i>Earl McDonald</i> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <i>2-2</i> , 19 <i>40</i>	
22. I HEREBY CERTIFY, That I attended deceased from <i>May 13</i> , 19 <i>39</i> , to <i>Feb 1</i> , 19 <i>40</i>	
I last saw him alive on <i>Feb 1</i> , 19 <i>40</i> Death is said to have occurred on the date stated above, at <i>5 P.</i> m.	
The principal cause of death and related causes of importance were as follows: <i>Carcinoma of prostate</i>	
Other contributory causes of importance: <i>hypertensive pneumonia</i>	
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) <i>J. P. Manning</i> M. D. <i>556</i> (Address) <i>Skidmore of Mo</i>	

RECEIVED  
District Health Officer No. 11,  
District File Number 340-402  
Date Filed MAR-18 1940

DEC 29 1948

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.....

*William Campbell*  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*William Campbell*  
.....  
Licensed Embalmer No. *2620*

P. O. Address *Manlyth, Md*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 75-87

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 628

Primary Registration District 5390 5830

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Nodaway  
(b) City or town Green Rural  
(If outside city or town limits, give "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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway  
(c) City or town Deer Creek Rural  
(If outside city or town limits write "RURAL")  
(d) Street No. 9 Fd - 1 - Deer Creek Mo  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Daniel P. Brown

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced Deu

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased.

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

84

11

15

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.

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a)

(Data received local registrar)

(b)

Earl McDonald

(Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 2  
year \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

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 J. Mamm... (M. D. or other)

Address Spokane Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

