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

Do not use this space.

12713

1. PLACE OF DEATH
County Vernon — Registration District No. 880 — File No.
Township Walker — Primary Registration District No. 4533 — Registered No. 4
City Walker (No. , St. Ward)

2. FULL NAME Martha Elizabeth Brown
(a) Residence, No. Walker Mo Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Thornton S. Brown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb. 9 1868
7. AGE: YEARS 72 ~~82~~ MONTHS 1 DAYS 21 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife
9. Industry or business in which work was done, as silk mill, 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): Benton Ill

FATHER
13. NAME: James Wyatt
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky

MOTHER
15. MAIDEN NAME: Mary Ann Dunbar
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Pa

17. INFORMANT (ADDRESS): Thornton S. Brown Walker Mo
18. BURIAL, CREMATION, OR REMOVAL: Schell City Mo
PLACE: Green Lawn Cem DATE: April 1 1940
19. UNDERTAKER (ADDRESS): Mark Eichinger Nevada Mo
20. FILED: 4/1 1940 C. B. Davis Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 30, 1940

22. I HEREBY CERTIFY, That I attended deceased from Mar 29, 1940, to Mar 30, 1940
I last saw her alive on Mar 30, 1940 Death is said to have occurred on the date stated above, at 8:15 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Pulmonary Edema	3/28-40
Other contributory causes of importance:	
Paralysis	15 yrs

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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 .....
(Signed) C. B. Davis, M. D.
(Address) Walker 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.

Corrected by affidavit June 6-1940

RECEIVED
District Health Officer No. 7,
District File Number 4-40-630
Date Filed 4-12-40

No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12713

Registration District No. 880 Primary Registration District No. 4533 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Walker
(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)

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.

3. (a) PRINT FULL NAME Martha Elizabeth Brown

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

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 72 Months 1 Days 21 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4-1-40 (Date received local registrar) (b) C B Davis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30 year 1940 hour minute M.

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

Immediate cause of death Acute Pulmonary Edema

Due to

Due to

Other conditions Paralysis Bulbar
(Include pregnancy within 3 months of death)

C B Davis

Major findings:
Of operations

Of autopsy 81 N

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature C B Davis (M. D. or other)

Address Walker Mo Date signed

No. 2B
-2-21-40
#1 X22659

WHITE PLAINTY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County .....

(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 years, months or days)
In this community .....

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.

3. (a) PRINT FULL NAME .....

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

4. Sex ..... 5. Color or race ..... 5. (a) Single, widowed, married, divorced .....

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
			hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

WIFE OR HUSBAND
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)

WIFE OR HUSBAND
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month ..... day ..... year ..... hour ..... minute ..... M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

S-12713 1940