

JUN 13 1940 79
Registration District No. _____

Primary Registration District No. 4047

1. PLACE OF DEATH

(a) County BOONE
 (b) City or town Sturgeon
 (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 ALL OF LIFE
 years, months or days

3. (a) PRINT FULL NAME GEORGE WASHINGTON BROWN ⁶⁵⁰3. (b) If veteran, name war V 3. (c) Social Security No. None4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Tillie Brown 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased OCT. 5 1876
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
93 7 0 hr. _____ min.9. Birthplace AUBRAIN Co. Mo
(City, town, or county) (State or foreign country)10. Usual occupation RETIRED FARMER 9

11. Industry or business

12. Name THOMAS BROWN 918. Birthplace unknown
(City, town, or county) (State or foreign country)14. Maiden name unknown15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Eliza Spelman(b) Address Sturgeon Mo.17. (a) Burial (b) Date thereof MAY 7-1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation MT. PISGAH18. (a) Signature of funeral director Barnes & Borth(b) Address Sturgeon, Mo.19. (a) MAY 6-1940 (b) RE Borth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County BOONE
 (c) City or town STURGEON
 (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 MAY day 5
year 1940 hour 9 P.M. minute _____ M.21. I hereby certify that I attended the deceased from Nov. 10
1939 to MAY 5, 1940
that I last saw him alive on MAY 5, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death Sarcoma

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 Jeff H. Jomeix (M. D. or other) 300Address Sturgeon, Mo. Date signed 6/6/40

ms
4

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.....

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.

MISSOURI STATE BOARD OF HEALTH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. **17841**

Registration District No. **79**

Primary Registration District No. **4047**

Registrar's No. _____

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

PLACE OF DEATH:

(a) County Boone

(b) City or town Sturgeon
(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 _____ (Specify whether _____)

3. (a) PRINT FULL NAME Geo. Washington 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 m

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 93 Months 7 Days 0 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 May day 5 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 Sarcoma

of liver

Due to _____

Due to _____ 46

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 Joseph H. Jones M.D. or other _____

Address Sturgeon Mo. Date signed _____

SUPPLEMENTAL

S-17841