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Registration District No. 852 Primary Registration District No. 4518 Registrar's No.

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Milan, Mo
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 7
(d) Length of stay: In hospital or institution (Specify whether)
In this community 60 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn
(c) City or town Browning
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME JOHN C. BRECKENRIDGE BROWNING
(b) If veteran. name war. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 29
year 7 hour 30 minute 9, M.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Sophia Bell Browning 6. (c) Age of husband or wife if alive years
7. Birth date of deceased March 4, 1861 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 20, 1940, to May 28, 1940, that I last saw him alive on May 28, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration

8. AGE: Years 79 Months 2 Days 25 If less than one day hr. min.

Due to anemia!
Due to Atherosclerosis

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

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

10. Usual occupation Farmer
11. Industry or business Farming

MOTHER FATHER
12. Name John A. Browning
13. Birthplace Kentucky
14. Maiden name Sophia Bell Lucia
15. Birthplace Kentucky

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

16. (a) Informant J. Chester Browning (b) Address Milan, Mo

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence

17. (a) Burial (b) Date thereof May 30, 1940 (c) Place: burial or cremation Union Grove

(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? 76?

18. (a) Signature of funeral director (b) Address Milan, Mo

(e) Means of injury
23. Signature Quinn H. Beckel (M. D. or other) 3
Address Milan Mo Date signed 3/29/40

19. (a) June 6 (b) Leo Hagan (Date received local registrar) (Registrar's signature)

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

932

RECEIVED

District Health Officer No. 10

District File Number 6-40-1203

Date Filed JUN 11 1940

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 _____

Frank D. Schoene

Registered Apprentice No. _____

working under my personal supervision.

Signed *Frank D. Schoene*

Licensed Embalmer No. 2916

P. O. Address Milan, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19755

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 852

Primary Registration District No. 43-18

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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
In this community (Specify whether 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

John Breckenridge 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 w

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 79 Months 2 Days 25-
If less than one day hr min

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

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)

(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 May day 22
year 1940 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 Acute myocardial infarction

Due to Myocardial infarction

Due to Coronary atherosclerosis

Other factors Arteriosclerosis

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 J. H. Becker M.D. (other)

Address Milan Mo Date signed

SUPPLEMENTAL

