

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24538**

Registration District No. **54**

Primary Registration District No. **5086**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Bates**
(b) City or town **Rural (Hudson) Mo**
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location) **Home**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **69 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED

(a) State **Mo** (b) County **Bates**
(c) City or town **Rural**
(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 **LOUISA SUSAN BROWNING**

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

4. Sex **female** 5. Color or race **White** 6. (a) Single, widowed, married; divorced **Widow**
6. (b) Name of husband or wife **Francis Philip Browning** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Mar 07 1833** (Month) (Day) (Year)

8. AGE: Years **85** Months **4** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Missouri Co West Va** (City, town, or county) (State or foreign country)

10. Usual occupation **House Keeping**

11. Industry or business _____

12. Name **Dr. Caleb Johnson**

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

14. Maiden name **Laura J. Beard**

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

16. (a) Informant **Ernest E Browning**

(b) Address **Appleton City, Mo**

17. (a) **Burial** (b) Date thereof **7-21-40** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Baptist cem Bates Co**

18. (a) Signature of funeral director **Frank J. H.**
(b) Address **Appleton City, Mo**

19. (a) **7-26-40** (b) **Mrs. Pauline Bain** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jul** day **18** year **1940** hour **10:30** minute **am** M.

21. I hereby certify that I attended the deceased from **Jan 4**, 19**40**, to **Jul 18**, 19**40**, that I last saw him alive on **Jul 17**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to _____

Due to **old**

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? **ACIB**

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

23. Signature **W. H. [unclear]** (M. D. or other) **MD**

Address **Appleton City, Mo** Date signed **7-18-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 7,
District File Number 8-40-1091
Date Filed 8-7-40

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 me
on the 18th day July 1940, Registered Apprentice No. _____
working under my personal supervision.

Signed Frank Lee
Licensed Embalmer No. 1099
P. O. Address Applston City, N.C.

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.