No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 20 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27954

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 851

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

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 yrs. (Specify whether years, months or days)
In this community 7 yrs. 2 mo 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay
(c) City or town Missouri City
(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 Charles Thomas Brown
3. (b) If veteran, name war ?
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife ✓
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Not Known – about 1874 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
About 66	?	?	hr. min.

9. Birthplace Clay County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Coal Miner
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 Mrs. C. T. Brown (deceased)
(b) Address Missouri City, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 6 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Kirksville, Mo.
18. (a) Signature of funeral director Summers and Finnipaugh
(b) Address Kirksville, Mo.
19. (a) Aug 7 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3 year 1940 hour 5 minute 20 P.M.
21. I hereby certify that I attended the deceased from Jan 1, 1940 to Aug 3, 1940, that I last saw him alive on August 3, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Terminal Bronchopneumonia	5 da.
Due to Syphilitic Meningo Encephalitis	10 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death) 34	

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? 85
While at work? (Specify type of place) (e) Means of injury

23. Signature P. S. Tate (M. D. or other) 1
Address State Hosp. St Joseph Mo. Date signed 4-3-40

(Licensed Embalmer's Statement on Reverse Side)

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 E. T. Whitaker, Registered Apprentice No. 110. working under my personal supervision.

Signed Summers and Flinchpaugh

Licensed Embalmer No. 2159

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.