

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31317**

Registration District No. **5053**

Primary Registration District No. **31**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Barry**
(b) City or town **Washburn**
(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 **2**
In this community **50 years**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
(c) City or town **Washburn**
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **30**
year **1940** hour **3** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **1939**, 19____ to **Sept. 28**, 19**40**;
that I last saw her alive on **Sept. 28**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Nephritis**

Due to _____
Due to **1721**

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? **940**

23. Signature **Herbert N. Salzer** (M. D. or dentist)
Address **Cassville Mo.** Date signed **Oct 1**

3. (a) PRINT FULL NAME **Susan Mary Brown**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **John M. Brown** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Mar. 1 1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **6** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **New Orleans La**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Joe Winder**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Charles E. Sturman**

(b) Address **Washburn, Mo**

17. (a) **Burial** (b) Date thereof **Oct 2 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **King Cen.**

18. (a) Signature of funeral director **Kate L. ...**

(b) Address **Cassville Mo.**

19. (a) _____ (b) **Frieda Eden's**
(Date received local registrar) (Registrar's signature)

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

Dr. Salzer

RECEIVED

District Health Officer No. 6;

District File Number *1040-2690*

Date Filed *OCT 10 1948*

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.....

Eugene Wood

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Eugene Wood

Licensed Embalmer No. *3204*

P. O. Address *Cassville, 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. 31317
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 37

Primary Registration District No. 5053

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

1. PLACE OF DEATH:

(a) County Barry
(b) City Washburn, T.P.
(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 Susan Mary 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 wid

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 6 Days 23 If less than one day _____ hr _____ min

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joe Winston

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

14. Maiden name Unknown

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

16. (a) Informant Charles E. Durbin

(b) Address Washburn, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 2 40 (Month) (Day) (Year)

(c) Place: burial or cremation King Cemetery

18. (a) Signature of funeral director Bob Funeral Home

(b) Address Cassville, Mo.

19. (a) 11/19/40 (Date received local registrar) (b) Freda Edens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30 year 1940 hour 3:25 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Sept 28 1940 to Sept 30 1940 that I last saw her alive on Sept 28 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis

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 Glen W. Salzer (M. D. or other) _____

Address Cassville, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

