

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No. **196**

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Columbia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Zelis Tinsel State Cancer Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 days**
(Specify whether
In this community **42 years**
years, months or days)

3. (a) PRINT FULL NAME **DEWEY BROWIN**
3. (b) If veteran, name war **Unknown**
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 9, 1898**
(Month) (Day) (Year)

8. AGE: Years **42** Months **2** Days **28**
If less than one day hr. _____ min. _____

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **W. E. Brown**
18. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Tinsel**
15. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Record**
(b) Address **Columbia, Mo.**

17. (a) **Burial** (b) Date thereof **Sept 9, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New Providence**

18. (a) Signature of funeral director **Charles W. D. M.**
(b) Address **Salisbury, Mo.**

19. (a) **9/9/40** (b) **Allie Selby**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**
(c) City or town **Columbia**
(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 **7**
year **1940** hour **3** minute **40** A.M.

21. I hereby certify that I attended the deceased from **August 20**
19**40**, to **Sept. 7** 19**40**;
that I last saw him alive on **Sept. 6** 19**40**.
and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage into abdomen** Duration **5 min.**
Due to **Peritonitis, localized** **7 days**

Due to **Gastric Ulcer, post-op** **5 mos.**

Other conditions _____
(Include pregnancy within 3 months of death) **117W**

Major findings: **Gastric ulcer, penetrating type**
Of operations _____
Of autopsy **Hemorrhage**

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? **74**

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

23. Signature **Theodore P. Clark** (M. D. or other) **M.D.**
Address **Columbia, Mo.** Date signed **7/7/40**

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

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 W. N. Whitfield

Licensed Embalmer No. 2893

P. O. Address Baltimore Md

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.