

S. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32038

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 756

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

1. PLACE OF DEATH: GREENE
 (a) County GREENE
 (b) City or town SPRINGFIELD
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 403 W. DIVISION
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME FANNIE BROWN.
 8. (b) If veteran, name war NO
 3. (c) Social Security No. NO.

4. Sex Female 5. Color of hair White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Walter Brown
 6. (c) Age of husband or wife if alive Dec. 1849
 7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 91 Months 5 Days 15 If less than one day

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

10. Usual occupation House Work
In home

11. Industry or business
 { 12. Name Unknown
 13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown England
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fannie Brown
 (b) Address Springfield, Mo.

17. (a) Final (b) Date thereof Sept 18 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director L. W. Klingner
 (b) Address Springfield, Mo.

19. (a) Sept. 18, 1940 (b) W. E. Haudley M.D.
 (Date of issue) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 403 W. Division
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 16
 year 1940 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 4, 1940, to Sept. 16, 1940
 that I last saw her alive on Sept. 16, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic
with decompensation
 Duration 1 yr.

Due to _____
 Due to _____

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

Major findings: _____
 Of operations _____
 Of autopsy _____
 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?
no

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

23. Signature C. E. Feller (M. D. or other) _____
 Address Springfield Mo. Date signed _____

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.

William Paul Rhodes
Signed

Licensed Embalmer No. *4071*

P. O. Address *Princeton*

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.