

Registration District No. FILED OCT 28 1940

Primary Registration District No. 5535

Registrar's No.

1. PLACE OF DEATH: FILED OCT 23 1940
 (a) County Howell
 (b) City or town Rural - Howell Twp.
 (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
25 years (Specify whether years, months or days)

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

4. Sex Fem 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Tom O. Brown 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased April 17, 1890
 (Month) (Day) (Year)

8. AGE: Years 50 Months 4 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business 1

12. Name Oliver L. Holland

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

14. Maiden name Mary B. Robison

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

16. (a) Informant Tom O. Brown
 (b) Address West Plains, Mo.

17. (a) Burial (b) Date thereof 9-14-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
Oak Lawn Cemetery

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Robertsons
West Plains, Mo.

(b) Address _____

19. (a) 9-14-40 (b) Vida W. Simons
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Howell
 (c) City or town Rural
 (If outside city or town limit, write "RURAL")
 (d) Street No. Rt. 1, West Plains
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
 year 1940 hour 11:50 minute 7 M.

21. I hereby certify that I attended the deceased from Sept. 1 1940 to Sept. 12 1940
 that I last saw her alive on Sept. 12 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Lung
Cancer of uterus
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____
 Of operations _____
 Of autopsy _____

Duration _____
 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? _____

(Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature W. H. Ogden
West Plains, Mo. (Date) 9/30/40
 Address _____ Date _____

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

RECEIVED

District Health Officer No. 5,

District File Number. 1040 972

Date Filed _____

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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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 32176

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 5835-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Howell T.P.
(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 _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Alice Cora 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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 30 Months 4 Days 25- If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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.

20. DATE OF DEATH: Months Sept day 12
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Lung
Cancer of uterus Duration _____

Due to CANCER of UTERUS
Primary

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death) 4/8

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? _____

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

23. Signature R. E. Hagan md (M. D. or other) _____
Address West Plains Mo Date signed _____

SUPPLEMENTARY

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

