

39006

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 444Primary Registration District No. 4262Registrar's No. 70

1. PLACE OF DEATH:

(a) County Knox
(b) City or town Knox City
(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 address)

(d) Length of stay: In hospital or institution _____
(Specify whetherIn this community _____
years, months or days)8. (a) PRINT FULL NAME DAVID E. BROWNING

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced M6. (b) Name of husband or wife Rosa Browning 6. (c) Age of husband or wife if alive 75 years7. Birth date of deceased MAY 25 1965
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
77 5 10 hr. min.9. Birthplace Bosco IL
(City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business _____

12. Name DAVID M. BROWNING 9
13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name LUCINDA DAVIS
15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant David Browning(b) Address Knox City Mo17. (a) Burial (b) Date thereof Nov 27 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Knox City Cemetery18. (a) Signature of funeral director Geo. V. Baskett(b) Address Wyaland, Mo19. (a) Nov 22 1940 (b) Mo C. M. Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Knox(c) City or town Knox City Mo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5
year 1940 hour 7 minute 40 P. M.21. I hereby certify that I attended the deceased from Nov 5
1940, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Struck by an automobile instant death - Duration _____

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? Knox City Knox Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? 3:05 (Specify type of place)
(e) Means of injury _____23. Signature Gial M. Reynolds (M. D. or other) _____Address Knox City Mo Date signed Nov 28 40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3. No. _____
5-17-39
I X21492

52

DEC 11 1940

210 M
21

Ly.

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

Geo V. Borbeck

Licensed Embalmer No. 1817

P. O. Address Wyaconda 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. 39006

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 444

Primary Registration District No. 4267

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Knox city
(b) City or town Knox city
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME David E. Browning

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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 77 Months 5 Days 10 If less than one year _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) _____ (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 5 year _____ hour _____ minute _____ M.

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

Immediate cause of death Stroke by an automobile instant death

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 210 m

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) Accident

(b) Date of occurrence Nov 5 - 1940

(c) Where did injury occur? West City Mo (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Walking across main highway in town
While at work? _____ (Specify type of place)
fractured leg above ankle + fracture of hip (e) Means of injury Auto

23. Signature Paul M. Reynolds (M. D. or other) _____

Address West City Mo Date signed 1-30-41

SUPPLEMENTARY

S-39006 - 1940