

5-17-39  
P I X21492

DEC 11 1951

5768

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Berea, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Janice Barr  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3  
In this community 7 weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Georgia (b) County \_\_\_\_\_  
(c) City or town Edison  
(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. 44 yrs. years.

3. (a) PRINT FULL NAME ARON BROWN

8. (b) If veteran, name war no (c) Social Security No. none

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Anne May Brown 6. (c) Age of husband or wife if alive 1896 years

7. Birth date of deceased Sept 10 - 1896  
(Month) (Day) (Year)

8. AGE: Years 44 Months 6 Days 17 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Lab Worker

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unknown ?  
13. Birthplace unknown ?  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name unknown  
15. Birthplace unknown ?  
(City, town, or county) (State or foreign country)

16. (a) Informant Anne May Brown

(b) Address Berea, Mo.

17. (a) Burial (b) Date thereof Oct 28 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flatt's Chapel

18. (a) Signature of funeral director Provis  
(b) Address East Gaines, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27<sup>th</sup>  
year 1940 hour 4 minute 30A M.

21. I hereby certify that I attended the deceased from Inquest 19 \_\_\_\_\_ 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 These stab knife wounds to the heart & 7 other places  
Due to free body  
Murder with Knife  
Due to Stab wounds

Other conditions (Include pregnancy within 3 months of death) 174

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) murder  
(b) Date of occurrence Oct 27<sup>th</sup> 1940  
(c) Where did injury occur Stennis Camp, Miss Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at a gambling place  
(Specify type of place)  
(e) Means of injury knife  
Signature Frank S. Young (M. D. or other)  
Address Charleston Mo Date sign \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 2

District File Number 240-177

Date Filed 12/9/40

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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 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. 39246  
Registrar's No. \_\_\_\_\_

Registration District No. 1051

Primary Registration District No. 5768

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

**1. PLACE OF DEATH:**

(a) County Miss

(b) City or town James Bay  
(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.  
In this community 7 weeks (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Aron Brown

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

4. Sex M 5. Color or race negro 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased Sept 10 1899  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>44</u>	<u>1</u>	<u>17</u>	_____ hr _____ min

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

10. Usual occupation Day laborer

11. Industry or business \_\_\_\_\_

12. Name Miss

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 Annal May Brown

(b) Address Dorena

17. (a) \_\_\_\_\_ (b) Date thereof Oct 28 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 4-4-41 (b) Miss Della Brown  
(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.

**20. DATE OF DEATH** Month Oct day 27  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ 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 3 stab wounds near heart 9 or 10 others over the body  
Due to murdered with knife stab wounds

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**

Duration \_\_\_\_\_

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) homicide

(b) Date of occurrence 10-27-1940

(c) Where did injury occur? Miss. Co. Miss.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at a gambling house.  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury knife

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

S-39246 1940