

FILED DEC 11 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

39633  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 775  
(b) Township \_\_\_\_\_ Primary Registration District No. 6020-a Registered No. 73  
(c) City Boone Terre (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Sarah O Brown  
(a) Residence, No. Boone Terre by Russell (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Samuel Brown  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/6/1854  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
86 7 23  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME William Dorton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

MOTHER 15. MAIDEN NAME Sarah Dorton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Samuel Brown  
Leadwood, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Doe Run DATE 11/9

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Boynton  
Leadwood, Mo

20. FILED Nov 28, 1940 N. W. Hewkins  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6, 1940

22. I HEREBY CERTIFY, That I attended deceased from 11-5, 1940, to 11-6, 1940

I last saw h. or alive on 11-5, 1940 Death is said to have occurred on the date stated above, at 10:45 p.m.  
The principal cause of death and related causes of importance were as follows:

Intercranial hemorrhage Date of onset 11-5-40

Other contributory causes of importance: arterio-sclerosis general

Name of operation none Date of no  
What test confirmed diagnosis? clinical Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) N. O. Sailer, M. D.  
(Address) Leadwood, Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

*Bert L. Boyer*

Licensed Embalmer No. *34045*

P. O. Address *Leadwood*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**