

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41694  
Registrar's No. \_\_\_\_\_

Registration District No. 2 Primary Registration District No. 2-81

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Wadaway Township Lincoln  
(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 60 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town RURAL Lincoln  
(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.

3. (a) PRINT FULL NAME MARY ROSELLA BROWNLEE

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 240

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife David Brownlee 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased 4-3-1861  
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Winter Settt Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

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

12. Name DAN BOLKER

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

14. Maiden name in known

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

16. (a) Informant's own signature DAVID BROWNLEE

(b) Address Wadaway mo

17. (a) B (b) Date thereof 12-5-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation buried mo

18. (a) Signature of funeral director E. L. G. G. G.

(b) Address Savannah mo

19. (a) Dec 5-40 (b) J. W. Holcomb  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 1  
year 1940 hour 6 minute 8 A. M.

21. I hereby certify that I attended the deceased from Nov 29, 1940, to Dec 1, 1940  
that I last saw him alive on Nov 29, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Brainial pneumonia Duration 7 days

Due to sepsis

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? \_\_\_\_\_ (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 J. W. Holcomb (M. D. or other) MD

Address Savannah mo Date signed 12-3-40

N. B.—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.

**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.....

*E. G. Breit*

Licensed Embalmer No.....

*2650*

P. O. Address.....

*Savannah Ga*

**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. 41694

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 2

Primary Registration District No. 201

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

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Linsell 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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

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.

3. (a) PRINT FULL NAME

Mary Rosella Brownlee

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased 4 - 3 1861  
(Month) (Day) (Year)

8. AGE: Years 79 ~~78~~ Months 7 Days 29  
If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) Dec 5 - 1940 (b) J. W. Holcomb  
(Date received local registrar) (Registrar's signature)

DECLARATION OF DEATH

20. DATE OF DEATH Month 12 day 1  
year \_\_\_\_\_ 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 \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature P. R. Kelley (M. D. or other) \_\_\_\_\_

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

SUPPLEMENTAL COPY

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

MOTHER FATHER

S-41694 1940