

Registration District No. _____

Primary Registration District No. **4641**

Registrar's No. **4**

1. PLACE OF DEATH:

(a) County **Boone**

(b) City or town **Centralia**
(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**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo**

(b) County **Boone**

(c) City or town **Centralia**
(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 **JOSEPH SAMUEL BROWN**

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 **Widowed**

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

7. Birth date of deceased **16 - 18 - 58**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **28th** year **1940** hour **3** minute **30 P.**

21. I hereby certify that I attended the deceased from **12/21/40**, 19____ to **12/28/40**, 19____; that I last saw him alive on **12/28/40**, 19____; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
82	11	12	hr. _____ min. _____

Immediate cause of death **Asymptomatic pneumonia**

Due to **Gastric**

Due to _____

Other conditions **HN**
(Include pregnancy within 3 months of death)

9. Birthplace **Boone Co Mo.**
(City, town or county) (State or foreign country)

10. Usual occupation **City Marshall**

11. Industry or business _____

12. Name **H. H. Brown**

13. Birthplace **Callaway Co Mo**
(City, town or county) (State or foreign country)

14. Maiden name **May DeForest**

15. Birthplace **Boone Co Mo.**
(City, town or county) (State or foreign country)

16. (a) Informant **May Gay Johnson**

(b) Address **La Grange Mo.**

17. (a) **Burial**
(Burial, cremation or removal)

(b) Date thereof **12 - 30 - 40**
(Month) (Day) (Year)

(c) Place: burial or cremation **Centralia Mo**

18. (a) Signature of funeral director **H. H. DeForest**

(b) Address **Centralia Mo**

19. (a) **12/30/40**
(Date received local registrar)

(b) **H. H. DeForest**
(Registrar's signature)

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? **360**
(Specify type of place) (e) Means of injury _____

23. Signature **H. H. DeForest** (M. D. or other) **MD**

Address **Centralia Mo** Date signed **12/28/40**

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

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

M. J. McDaniel

Licensed Embalmer No. *2589*

P. O. Address *Centralia 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, fact should be so stated above.