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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

APR 15 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11775

Registration District No. 726

Primary Registration District No. 5957

Registrar's No.

1. PLACE OF DEATH

(a) County Ralls

(b) City or town New London
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED: 87

(a) State Missouri (b) County Ralls

(c) City or town New London
(If outside city or town limits, write "RURAL") 0

(d) Street No. P. O. (If rural, give location)

(e) If foreign born, how long in U. S. A? 11 years.

3. (a) PRINT FULL NAME Marshall H. Brown

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased April 12 1879
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March, day 23
year 1941 hour _____ minute 10^a M.

21. I hereby certify that I attended the deceased from viewed Dept Body
March-23, 1941, to _____, 19____;
that I last saw him alive on body - March-23, 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years 62 ✓ Months 11 Days 11
If less than one day _____ hr. _____ min.

9. Birthplace Ralls Mo D
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Immediate cause of death Myocardial Failure

Due to _____

Due to _____

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

MOTHER FATHER

11. Industry or business _____

12. Name J. Charles Brown

13. Birthplace Ralls Mo D
(City, town, or county) (State or foreign country)

14. Maiden name Ada Dobb

15. Birthplace Ralls Mo D
(City, town, or county) (State or foreign country)

16. (a) Informant Wald Brown
(b) Address 310 N 7th Hannibal Mo

17. (a) Burial (b) Date thereof May 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barkley

18. (a) Signature of funeral director James O'Connell
(b) Address Hannibal Mo

19. (a) Mich 26 1941 (b) Blanche Megown
(Date received local registrar) (Registrar's signature)

Major findings: Of operations X

Of autopsy X

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? 653

While at work? _____ (Specify type of place) (e) Means of injury 3

23. Signature H E Caldwell Corner
(M.D. or other) _____
Address New London Date signed 3/24/41

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

200 a

RECEIVED

District Health Officer No. 10

District File Number 4-41-735

Date Filed APR 10 1941

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 Michael J. Jones

Licensed Embalmer No. 3246

P. O. Address Hannibal, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11775-

Registration District No. 726

Primary Registration District No. 5957

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls

(b) City or town Spencer T.P.
(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 _____
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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Marshall A Brown

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Mar day 23
year _____ hour _____ minute _____ M.

4. Sex m

5. Color or race w

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

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Immediate cause of death Myocardial failure Duration _____

8. AGE: Years 62 Months 11 Days 11
If less than one day _____ hr. _____ min.

Due to Myocarditis

Due to _____

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

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

10. Usual occupation _____

Major findings: _____
Of operations _____

11. Industry or business _____

of autopsy _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

22. If death was due to external cause, 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 W. E. Caldwell (M. D. or other) _____

Address New London Date signed 6/18/41

SUPPLEMENTARY

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11775-

Registration District No. 726

Primary Registration District No. 5957

Registrar's No. _____

1. PLACE OF DEATH

- (a) County Ralls
 - (b) City or town Shenandoah T. O.
(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 _____
years, month 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 23
year 1941 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 _____ Duration _____

Due to _____

Due to _____

Under conditions _____
(Include pregnancy within 3 months of death)

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? _____

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

23. Signature H. E. Caldwell (M. D. or other) _____

Address New London Mo Date signed _____

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

3. (a) PRINT FULL NAME Marshall H. 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 M

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

7. Birth date of deceased. Apr 12 (Month) (Day) (Year) 1899

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>11</u>	<u>11</u>	hr. _____ 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) 3/26 1941 (b) Blanche McGraw
(Date received local registrar) (Registrar's signature)