

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **24967**FILED AUG 14 1941
Registration District No. **2287**Primary Registration District No. **5357**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County **W. Kalb**
(b) City or town **Rural (Candlen)**
(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 **years** (Specify whether years, months or days)
In this community **years**

3. (a) PRINT FULL NAME **John M. Brown**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **88**

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

6. (b) Name of husband or wife **Ruth H. Brown** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **October 20 1857**
(Month) (Day) (Year)

8. AGE: Years **83** Months **8** Days **10** If less than one day hr. min.

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

10. Usual occupation **Physician**

11. Industry or business _____

12. Name **William Brown**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Catharine**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Ruth H. Brown**

- (b) Address **Mayville Mo**

17. (a) **Burial** (b) Date thereof **July 3 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation **Mayville Cemetery**

18. (a) Signature of funeral director **J. F. Brown**

- (b) Address **Mayville Mo**

19. (a) **7-1-41** (b) **John M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **W. Kalb**
(c) City or town **Rural**
(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. **fifty 0** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1**
year **1941** hour **8** minute **30** A. M.

21. I hereby certify that I attended the deceased from **JUNE 14**, 19**41**, to **JULY 1**, 19**41**;
that I last saw him alive on **JUNE 30**, 19**41**;
and that death occurred on the date and hour stated above.

- Immediate cause of death **HYPOTATATIC BRONCHOPNEUMONIA 12 HRS.**

- CORDINARY SCLEROSIS UNDET.**

- Due to **GENERALIZED ARTERIOSCLEROSIS**

- WITH HYPERTENSION; MYOCARDITIS UNDET.**

- Due to _____

- Other conditions (Include pregnancy within 3 months of death) **93 1/2**

- Major findings: Of operations _____

- Of autopsy _____

- 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? _____

- (Specify type of place)

- (e) Means of injury _____

23. Signature **John M. Coon M.D.** (M. D. or other) **MD**

- Address **MAYVILLE MO** Date signed **7-2-41**

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. 952

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.