

FILED SEP 13 1941

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

28914  
Do not use this space.

1. PLACE OF DEATH  
 (a) County New Madrid Registration District No. 55  
 (b) Township Auderson Primary Registration District No. 6262 Registered No. 88  
 (c) City Paducah (d) Street No. 1 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. ds. 0 How long in U. S., if of foreign birth? yrs. mos. ds. 0

2. PRINT FULL NAME Altha Izetta Brown  
 (a)  Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 - 1940  
 7. AGE YEARS MONTHS DAYS 10 06 14 If LESS than 1 day, 17 hrs. or 15 min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. cleaner  
 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) Auderson Mo.  
 FATHER 13. NAME Wilbore Brown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 MOTHER 15. MAIDEN NAME Grace Osburn  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 17. INFORMANT (ADDRESS) Wilbore Brown Auderson Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE W. Ballou DATE 8/30 1941  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Loyd Russell 2199 5th Ave  
 20. FILED Aug 30, 1941 Zelda Mason Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 29 1941  
 22. I HEREBY CERTIFY, That I attended deceased from Aug 20 1941 to Aug 29 1941  
 I last saw her alive on Aug 29 1941 Death is said to have occurred on the date stated above, at 10 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Whooping Cough, Bronchial Pneumonia, Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 9  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Diagnosed Was there an autopsy? No  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No Date of injury None  
 Where did injury occur? None (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury None  
 Nature of injury None  
 24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) W. B. Ballou, M. D.  
 (Address) Auderson Mo

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.

RECEIVED

District Health Office - No. 2,

District File Number 941-1265

Date Filed 9/11/41

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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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28914  
Registrar's No. 88

Registration District No. 55 Primary Registration District No. 6262

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Padon  
(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 Missouri (b) County New Madrid  
(c) City or town Padon - Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Altha J. Brown

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased Oct 14 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 10 Days \_\_\_\_\_ 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) Oct 11 '41 (b) Helen Mason  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day 19 year 41 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him/her 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

