

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Madison
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether years, months or days)
In this community lifetime years, months or days

3. (a) PRINT FULL NAME Albert Black Brownfield

8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Carrie Doyle Brownfield 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased 10/18/1879
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 9 If less than one day hr. min.

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

10. Usual occupation retired rural r carrier

11. Industry or business none

12. Name William S. Brownfield

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

14. Maiden name Mollie Hinebaugh

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

16. (a) Informant's own signature Doyle G. Brownfield

(b) Address Madison Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/41
(Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Fred A. Thompson

(b) Address Madison, Missouri

19. (a) 9/27/41 (Date received local registrar) (b) Mrs. Jessie Thompson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe
(c) City or town Madison
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1941 hour 8 minute _____ A.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 Coronary thrombosis Duration 3 yrs.

Due to _____

Due to _____

Other conditions 9/4/41
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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 W. H. Turner (M.D. or other)

Address Madison Mo. Date signed 9/27/41

PLEASE PRINT IN BLACK INK—MAKE A PERMANENT RECORD

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.

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NOV 12 1941

RECEIVED

District Health Officer No. 10

District File Number 10-41-1903

Date Filed OCT 24 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 Paul A. Thompson

Licensed Embalmer No. 1420

P. O. Address Madison, 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, above space should be left blank.