

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35544**

Registration District No. **576**

Primary Registration District No. **576265**

Registrar's No. **713**

1. PLACE OF DEATH:

(a) County **Mississippi**
(b) City or town **Wyatt**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **No street numbers**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mississippi**
(c) City or town **Wyatt**
(If outside city or town limits, write "RURAL")
(d) Street No. **No street numbers**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Burnett Brown**

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

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

6. (b) Name of husband or wife **Allie Ray Brown** 6. (c) Age of husband or wife if alive **34** years

7. Birth date of deceased **March 10 1920**
(Month) (Day) (Year)

8. AGE: Years **21** Months **7** Days **2** If less than one day hr. min.

9. Birthplace **Burnett / Texas**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **At Home**

12. Name **John W. Evans**

13. Birthplace **Carrol Co. / Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Mamie York**

15. Birthplace **Carrol Co. / Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mamie York**
(b) Address **Wyatt, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-13-41**
(Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove-Charleston, Mo.**
Lair-Nunnelee
(d) Signature of funeral director **Charleston, Mo.**
(e) Address **10-18-41**
(Date received local registrar) (b) **F. Overman**
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **12th.**
year **1941** hour **3** minute **15** P.M.

21. I hereby certify that I attended the deceased from **Sept 5 1941**
to **Oct 3 1941**
that I last saw her alive on **Oct 1 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Nephritis**
Duration **5 weeks**

Due to
Due to

Other 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?

(Specify type of place)
While at work? (e) Means of injury
23. Signature **F. Overman** (M. D. or other)
Address **Charleston Mo.** Date signed **10-12-41**

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

MOTHER FATHER

7
0
0

0
0

PHYSICIAN

2310

RECEIVED

District Health Office No. 2,

District File Number 1141-1480

Date Filed 11/3/41

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

John P. Minnie Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, W. Va.

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. 35544

Registration District No. 566

Primary Registration District No. 5765

Registrar's No. _____

1. PLACE OF DEATH

(a) County Mississippi
(b) City or town Wydell
(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 Burnett 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 Mar 10 1941
(Month) (Day) (Year)

8. AGE: Years 21 Months 7 Days 14 (If less than one day _____) min. _____

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 12 Year 1941 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I have seen him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis
Duration _____

Due to Undetermined
Due to _____

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

Major findings: Of operations 130
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 Paul S. Baur (M. D. or other) _____
Address Charleston Mo Date signed 12/12/41

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

SUPPLEMENTARY

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

S-35544