

FILLED NOV 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35974

Registration District No. 273

Primary Registration District No. 6018A

Registrar's No. 138

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town (near) Farmington - Missouri
(c) Name of hospital or institution:
State Hospital No. 4
(d) Length of stay: In hospital or institution 34 yr. 4 mos. 13 d. S.
In this community years, months or days

3. (a) PRINT FULL NAME Ann Brown

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

4. Sex F. 5. Color of race W. 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 72 Months U.K. Days U.K. If less than one day hr. min.

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

10. Usual occupation U.K. unknown

11. Industry or business U.K.

MOTHER FATHER { 12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Records of State Hospital No. 4
(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof Oct-3-41
(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director C. Hugo Cozart
(b) Address Farmington

19. (a) Oct 3 1941 (b) B. B. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste. Genevieve
(c) City or town
(d) Street No.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1st year 1941 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from 1941 to October 1st, 1941 that I last saw her alive on October 1st, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerosis, generalized and marked

Due to 97

Other conditions: Chronic Myocarditis, Pericarditis, Coronary Artery Disease, Slight Paralysis (Slight Strokes)

Major findings: Of operations: no operations
Of autopsy: no 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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature C. C. Oult (M.D. or other) M.D.
Address Farmington, Missouri Date signed 10/3/41

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

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.

Not
Signed *Embalmed*
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, fact should be so stated above.