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FILED SEP 9 1942  
Registration District No. 324

Primary Registration District No. 3072

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

1. PLACE OF DEATH:

(a) County Dalaine

(b) City or town Marshall Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Elizabeths Mem. Hosp. O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 hrs  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis MO

(c) City or town Houstonia  
(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 Zuma E Brown

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 13  
year 1942 hour 3 minute 45 A.M.

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

6. (b) Name of husband or wife Bert Brown 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Jan 9 1890  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 11 1942 to Aug 13 1942

that I last saw her alive on Aug 1942 and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 7 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Surgical Shock Duration 1

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

Due to Uterine Fibroid.  
& Appendectomy.

10. Usual occupation house wife

Other conditions Chor. Myocarditis.  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

Major findings: Chor. myocarditis, Uterine Fibroid, Chor. Seminiferous G. Ovarian (Black Ovary)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Thomas Hill

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

14. Maiden name Alta Caswell

15. Birthplace Pine Creek MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Bert Brown

(b) Address Houstonia

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (yes) No

(b) Date of occurrence No

17. (a) burial (b) Date thereof Aug 16 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unaford

(c) Where did injury occur? No  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No

18. (a) Signature of funeral director Wesbrook

(b) Address Houstonia MO

While at work? No (Specify type of place) (e) Means of injury No

19. (a) Aug 14, 1942 (b) MO T. D. Westover  
(Date received local registrar) (Registrar's signature)

23. Signature Robert M. ... (M. D. or other) \_\_\_\_\_  
Address Marshall Mo Date signed 8-13-42

1210 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 9-7-42

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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

*H. W. Smiley*

Licensed Embalmer No.

*3987*

P. O. Address

*Houstonia*

**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.**

41  
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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28291  
Registrar's No. 132

Registration District No. 324 Primary Registration District No. 3072

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Marshall  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(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)

3. (a) PRINT FULL NAME Juma E Brown  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 1890 years  
7. Birth date of deceased Jan 9 (Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 13 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Surgical shock Duration \_\_\_\_\_

Due to uterine fibroid  
of appendectomy  
Due to subtotal hysterectomy  
1. 2nd pelvic laparotomy  
Other conditions Ch. myocadetes  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations Ch. appendicitis uterine fibroid Ch. Salpingitis  
Of autopsy ovarian abscess old  
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 none  
(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) no (Specify type of place) (e) Means of injury none  
23. Signature Robert Marshall (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ (Date signed) 10-1-42

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

SUPPLEMENTARY

MOTHER FATHER

dist

