No. 2
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1943

Registration District No. 240

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4358

State File No. 7077

Registrar's No. 58

1. PLACE OF DEATH:
(a) County: New Madrid
(b) City or town: Lilbourn
(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 years, months or days)
In this community: 79 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Lilbourn
(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: 0

3. (a) PRINT FULL NAME: John Wesley Brown

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Lurie Brown

6. (c) Age of husband or wife if alive: 76 years

7. Birth date of deceased: April (Month) 15 (Day) 1863 (Year)

8. AGE: Years 79 Months 10 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace: New Madrid Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business: Farming

FATHER
12. Name: unknown
13. Birthplace: unknown (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Mrs. Lurie Brown
(b) Address: Lilbourn Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25 /43 (Month) (Day) (Year)
(c) Place: burial or cremation: New Madrid Mo.

18. (a) Signature of funeral director: Welsh Funeral Home
(b) Address: Sikeston Mo.

19. (a) 3-1-43 (Date received local registrar) (b) Mrs. J. L. Parrish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 24 day 24 year 1943 hour 3 minute 20 A. M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw him alive on Feb. 10, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Paralysis

Due to:

Due to:

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

Major findings:
Of operations:
Of autopsy:

Duration

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: G. N. Thieme (M. D. or other)
Address: Lilbourn Mo. Date signed: 3-24-43

1276 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 243-267
Date Filed 3-8-43

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7077

Registration District No. ..... Primary Registration District No. 4358 Registrar's No. .....

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Lilbourn (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 years, months or days)

In this community 79 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Lilbourn (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 John W 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 Lurie

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased ..... (Month) ..... (Day) ..... (Year)

8. AGE: Years 79 Months 10 Days 9 If less than one day ..... hr. ..... min.

9. Birthplace Mo (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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14 year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h..... alive on ..... 19...; and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Due to Paralysis: Cerebral hemorrhage

Due to .....

Other conditions ..... (Include pregnancy within 3 months of death) J 3a'

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)

(b) 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 G N Wilson (M. D. or other)

Address Lilbourn Mo Date signed 3-30-43