S. No. 2
M—5-42
-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 5 1943

Registration District No. 5

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17511

Primary Registration District No. 3009

Registrar's No. 23

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
416 Kate Street 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Girardeau 16 2 1
(c) City or town Jackson
(If outside city or town limits, write "RURAL")
(d) Street No. 416 Kate
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mary Elizabeth Browning

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7

5. Color or race W 1

6. (a) Single, widowed, married, divorced widowed 2

6. (b) Name of husband or wife James C. Browning

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

7. Birth date of deceased May (Month) 14 (Day) 1859 (Year)

8. AGE: Years 84 Months 0 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) Tennessee 1 (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Isaac M Day
13. Birthplace (City, town, or county) Tennessee 1 (State or foreign country)

MOTHER
14. Maiden name Sarah J. Sartin
15. Birthplace (City, town, or county) Tennessee 1 (State or foreign country)

16. (a) Informant Miss Ella Browning
(b) Address Jackson, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5 1943 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery, Jackson Mo.

18. (a) Signature of funeral director Wilson - Statler - Seabaugh
(b) Address Jackson Missouri

19. (a) 6/4 1943 (Date received local registrar) J H C Kerstner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2 year 1943 hour 3 minute — M.

21. I hereby certify that I attended the deceased from Feb 18, 1943 to June 2, 1943
that I last saw her alive on June 2, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myo Condito — Duration Don't Know

Due to

Due to

Other conditions Fractured Hip Feb 18-43
(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 115
(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 1

23. Signature D. L. Sidbury Jr. (M. D. or other)
Address Jackson Mo. Date signed 6-4-43

1116

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 643-229

Date Filed 6-7-43

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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, fact should be so stated above.

. S. No. 2B
0M—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. June

Registration District No. 52 Primary Registration District No. 3009 Registrar's No. 23

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Jackson
(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 Mary Elizabeth Brownway

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 14 (Day) 1859 (Year)

8. AGE: Years 84 Months 0 Days 20 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 June day 2
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.

	Duration
Immediate cause of death myocarditis	10 K
Due to	
Due to	
Other conditions Fracture Hip - 2-18-43 (Include pregnancy within 3 months of death)	

Major findings:
Of operations 1860
Of autopsy 10

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

22. If death was due to external causes, fill in the following: accident
(a) Accident, suicide, or homicide (specify) ~~2-19-43~~
(b) Date of occurrence 2-18-43
(c) Where did injury occur? Fall in home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Bed room (Specify type of place)
While at work? (e) Means of injury

23. Signature D. O. L. Dehaney (M. D. or other)
Address Jackson Mo Date signed 6-14-43

17511