

FILED JUL 12 1943

Registration District No. **187**

Primary Registration District No. **3040**

Registrar's No. **71**

1. PLACE OF DEATH:

(a) County **Linn**
(b) City or town **Chillicothe**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home - 1114 E. 1st St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 weeks**
(Specify whether
In this community **5 months**
years, months or days)

3. (a) PRINT FULL NAME **Estace U. Brown**

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

4. Sex **Male** 5. Color or Race **White** 6. (a) Single, widowed, married, divorced, widower
6. (b) Name of husband or wife **Phena May Taylor** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Sept 30 1866**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 9 12 hr. min.

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

10. Usual occupation **Carpenter**

11. Industry or business

12. Name **Samuel Brown, D.C.C.**
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name **Susan Jane Gordon**
15. Birthplace..... (City, town, or county) (State or foreign country) **9**

16. (a) Informant **Stella Arline Brown**

(b) Address **Lima Montana**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 20, 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation **Chillicothe, Mo.**

18. (a) Signature of funeral director **F. L. Smith**

(b) Address **Funeral Home**

19. (a) **JUL 19 1943** (Date received local registrar) (b) **L. O. U. Ellis** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn**
(c) City or town **Chillicothe**
(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 **June** day **18th**
year **1943** hour **9** minute **20 AM**

21. I hereby certify that I attended the deceased from **June 10 to June 18 1943**
that I last saw him alive on **6-18-1943** 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Hypertension
Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 months of death) **8301**

Major findings:
Of operations.....
Of autopsy **None**

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)
(c) Means of injury.....
23. Signature **W. L. Smith** (M. D. or other)
Address **Chillicothe Mo.** Date signed **6-19-43**

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

MOTHER FATHER

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 *Frank L Smiley*
Licensed Embalmer No. *470*
P. O. Address *Wheeling, 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.

Registration District No. 187

Primary Registration District No. 8040

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Challicothe
(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)

3. (a) PRINT FULL NAME Estate U. 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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 30 1900
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 20
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) JUNE 19 (b) Lev Elba Curry
(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 January Day _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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 _____

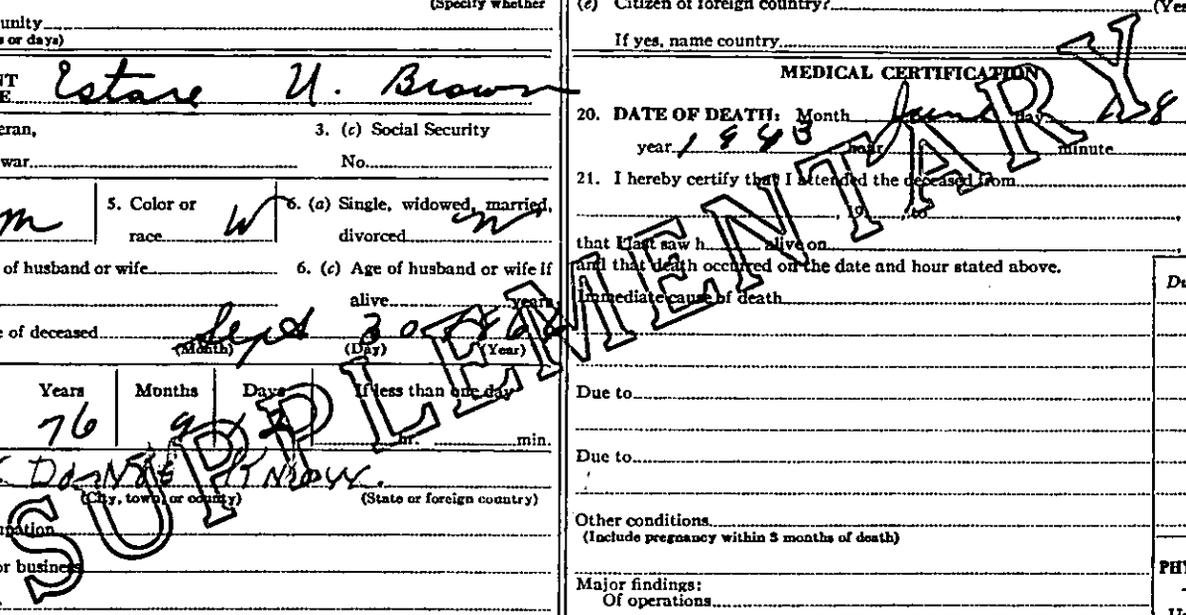
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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



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