

D. W. Harrison

State File No.

FILED APR 7 1944

Registration District No. *73001*

Primary Registration District No. *5467A*

Registrar's No. *49*

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield, Strafford
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 2, Strafford, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Strafford
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles William Brown
3. (b) If veteran, name war None
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
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 September 4, 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
28 6 6 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____
12. Name Charles W. Brown
13. Birthplace Rolla, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Bertha E. Parry
15. Birthplace Rolla, Missouri
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Mr. Charles W. Brown
(b) Address Strafford, Missouri
17. (a) Burial (b) Date thereof 3 / 13 / 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FAST LAWN CEMETERY
Alma Lohmeyer Funeral Home
18. (a) Signature of funeral director Springfield, Missouri
(b) Address _____

19. (a) 3/12 44 (b) Harrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10,
year 1944 hour 6:30 minute _____ P. M.
21. I hereby certify that I attended the deceased from 3-9-44 to 3-10-44
that I last saw him alive on 3-10
and that death occurred on the date and hour stated above.

Immediate cause of death, Mitral insufficiency
Due to shock and hemorrhage 2 days
Due to due to fall
Other conditions Epileptic
(Include pregnancy within 3 months of death)

Duration

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) accident
(b) Date of occurrence 3/8/44
(c) Where did injury occur? Home Greene Co Mo
(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 _____ (c) Means of injury fall

23. Signature W. I. W. W. W. (M. D. or other)
Address Springfield Mo Date signed 3/13/44

1246

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.....

Lewis E Scharpf

Licensed Embalmer No.....

3802

P. O. Address.....

Springfield,

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

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

2F
42
33930

APR 6

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 130

Primary Registration District No. 5463A

Registrar's No. 49

1. PLACE OF DEATH

(a) County Greene
(b) City or town Stafford Jackson Twp.
(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 Charles 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 s

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

7. Birth date of deceased Sept. 4
(Month) (Day) (Year)

8. AGE: Years 28 Months 6 Days 6 If less than one day, _____ min.

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

10. Usual occupation farmer

11. Industry or business farmer

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) _____ (b) Harold Harrison
(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 March Day _____ Year 1949 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

10960

FILED