

No. 2
5-43
5-17-39
X36671

FILED MAR 20 1944
Registration District No. **8601**

Primary Registration District No. **4450**

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

1. PLACE OF DEATH:

(a) County **Ripley Dornphan, Mo.**

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

(c) Name of hospital or institution: **Williams Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 hrs.**
(Specify whether years, months or days)

In this community (Yes or No)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Ripley**

(c) City or town **Oxley**
(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

3. (a) PRINT FULL NAME **MARY JO BROWN**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month **Feb** day **14** year **1944** hour **11:34** minute _____ M.

21. I hereby certify that I attended the deceased from **Feb-14** 19**44** to **Feb-14** 19**44**
that I last saw **her** alive on **Feb-14** 19**44**
and that death occurred on the date and hour stated above.

4. Sex **F** 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 **Feb 14 1944**
(Month) (Day) (Year)

Immediate cause of death **Asphyxia**
Premature birth

Due to _____

Due to _____

8. AGE: Years _____ Months _____ Days _____ If less than one day **5** hr. _____ min.

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

Major findings: _____

Of operations _____

Of autopsy _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Keece Brown Jr.**

13. Birthplace **Oxley Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Leah Jean Gattley**

15. Birthplace **Naylor Mo**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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16. (a) Informant _____ (b) Address _____

17. (c) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Antioch**

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? _____

18. (a) Signature of funeral director **Minnie Gish**

(b) Address **Naylor Mo**

19. (a) **Feb 14 1944** (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury **0**

23. Signature **E. Williams** (M. D. or other) _____
Address **Dornphan** Date signed **2/16/44**

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

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

1. PLACE OF DEATH:

(a) County Rapley
(b) City or town Wrensboro
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Williams Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-11
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary J. Brown

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 5

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

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

8. AGE: Years _____ Months _____ Days _____ Unless than one day _____ min.

9. Birthplace _____
(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 Mrs. Agnes Brown

(b) Address 270

17. (a) Burial (b) Date thereof 2-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wrensboro

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/26/44 (b) E. B. Johnston
(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 Feb day 14
year 1944 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 _____

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 _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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