

FILED APR 20 1944

Registration District No. _____

Primary Registration District No. 2007

State File No. _____

Registrar's No. 112

1. PLACE OF DEATH:

(a) County Butler County
(b) City or town Paplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Paplar Bluff Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community 46 yrs
years, months or days)

3. (a) PRINT FULL NAME ANNIE MARYANN BROWN

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife L. S. Brown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 9 1879
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
12. Name Ezekiel Ashley
13. Birthplace unknown a
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown a
(City, town, or county) (State or foreign country)

16. (a) Informant L. S. Brown

(b) Address Bernie Mo.

17. (a) Burial (b) Date thereof Apr 8 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bernie Mo.

18. (a) Signature of funeral director W. H. Isley
(b) Address Piggott Ark

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard
(c) City or town Bernie 103
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5
year 1944 hour 2:40 minute a M.

21. I hereby certify that I attended the deceased from 3-30 1944 to 4-5 1944,
that I last saw her alive on 4-4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arteriosclerosis + hypertension
Due to _____

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

Major findings: Of operations none
Of autopsy none

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 Wm. H. Hunsicker (M. D. or other) _____
Address Paplar Bluff Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No.

District File Number 444-

Date Filed 4-12-

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. 4444

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 112 J

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff
(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 Mary Ann Brown
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 m

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

7. Birth date of deceased July 9
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days _____ (less than one day) min. _____

9. Birthplace Mich.
(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) 4-6-44 (b) Belle Turner
(Data 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 April 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 _____

Duration

Due to _____

Due to _____

Other conditions (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 _____

(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

14236