

FILED JUN 3 1944
 DEPARTMENT OF HEALTH
 BUREAU OF THE CENSUS
 REG. DIST. NO. 127

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 18184
 Registrar's No. 5

Registration District No. 127

Primary Registration District No. 5563

1. PLACE OF DEATH:

(a) County Iron
 (b) City or town Rural; Liberty
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
6 miles S.E. of Arcadia
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community 5 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6 miles S.E. of Arcadia
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Theodore B. Brown

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Martha Brown 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased. April 27 1860
 (Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 2 If less than one day
 hr. _____ min. _____

9. Birthplace Madison County Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer; retired

11. Industry or business _____

MOTHER FATHER { 12. Name Stephen Brown
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Christine Smith
 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Mecey

(b) Address Arcadia Mo.

17. (a) burial (b) Date thereof May 1 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Arcadia Iron ton Mo.

19. (a) 5-6-44 (b) Mrs. Francis C Howard
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
 year 1944 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from
Apr. 26 1944 to Apr. 29 1944
 that I last saw him alive on Apr. 29 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days

Due to Apoplexy

Due to Hypertension

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

Major findings:
 Of operations _____
 Of autopsy _____
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?

(Specify type of place)
 While at work? _____ (a) Means of injury _____
 23. Signature F. H. Gale (M. D. or other) _____
 Address Bismarck Mo Date signed Apr 30 1944

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NOV 21 1953
CITY OF WASHINGTON

DEC 18 1953

JUN 2 1943

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..... *Priscilla White*

Licensed Embalmer No. *3012*

P. O. Address..... *South Me*

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. 144

Primary Registration District No. 5563

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Iron
(b) City or town Rural Liberty 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 Theodore B. 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.....

7. Birth date of deceased April 27 (Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 0 (If less 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..... (State or foreign country)

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)

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 year 1944 hour..... minute..... M.

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

Due to apoplexy

Due to hypertension

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

Major findings: Additional
Of operation lobar pneumonia
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) Means of injury.....

23. Signature F. J. Gale (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

18184