

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED MAY 17 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18608

Do not use this space.

1. PLACE OF DEATH

(a) County maries Registration District No. 207
(b) Township Jefferson Primary Registration District No. 5756
(c) City Belle (d) Street No. 1
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

HARRIETT AGNES BROWN
(a) Residence, No. St. □ (If nonresident, give city or town and State) 0
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James M. Brown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 13, 1870

7. AGE YEARS 73 MONTHS 10 DAYS 1 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Vienna (STATE OR COUNTRY) Maries Co. D

FATHER 13. NAME Robert B. Crum

14. BIRTHPLACE (CITY OR TOWN) Tennessee (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Harriett Agnes O. Neal

16. BIRTHPLACE (CITY OR TOWN) England (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Belle, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Union Hill DATE Apr. 15, 1944

19. FUNERAL DIRECTOR (NAME) W. E. Birmingham (ADDRESS) Cumma, Mo

20. FILED 5/4/44 Erma Barrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14, 1944

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1944 to April 14, 1944

last saw him alive on April 12, 1944. Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Asthma, Bronchial
Cardiac insufficiency
Date of onset

Other contributory causes of importance: 9503

Name of operation none Date of

What test confirmed diagnosis? no Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide no Date of injury no, 1944

Where did injury occur? no (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no

Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify no

(Signed) D. J. Jones, M. D.

(Address) Belle, Mo

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-15-44

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, ...

did not Embalm body

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, above space should be left blank.