

FILED JUN 20 1944

Primary Registration District No. **3007**

Registrar's No. **180**

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Arkansas** (b) County **Clay** **999**  
(c) City or town **Watts, Ark.** **3**  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country **2**

3. (a) PRINT FULL NAME

**Alta May Brown**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. **498-24-2330**

5. Color or race **Female** **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 **Aug** **2** **1907**  
(Month) (Day) (Year)

8. AGE: **36** Years **9** Months **19** Days  
If less than one day hr. min.

9. Birthplace **Watts, Clay Co. Ark.**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER {  
12. Name **Milton Brown**  
13. Birthplace **(near) Carlin, Illinois**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Lucie Rowlings**  
15. Birthplace **Organ county, Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Harriet Brown**  
(b) Address **Watts, Ark.**

17. (a) **Burial** (b) Date thereof **5-27-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Johnson Cem.**

18. (a) Signature of funeral director **W. H. Deby**

(b) Address **Watts, Ark.**

19. (a) **5-31-44** (b) **Belle Turner**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **21**  
year **1944** hour **12** minute **01 A.M.**

21. I hereby certify that I attended the deceased from **May 15**, 1944, to **May 21**, 1944,  
that I last saw her alive on **May 21**, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary embolus**  
Due to **hypertension for multiple uterine fibroids 2 yrs** **5 days**  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **56 lb**

Major findings:  
Of operations **multiple fibroids of uterus**  
Of autopsy **56 lb**

Duration

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) **4/3**  
(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 & place)  
(e) Means of injury **3**

23. Signature **W. H. Deby** (M. D. or other)  
Address **Poplar Bluff, Mo.** Date signed **5-25-44**

RECEIVED

District Health Office

District File Number *6-14-*

Date Filed *6-18-9*

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. \_\_\_\_\_  
Registrar's No. 180

FILED JUL 20

Registration District No. 4 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Pepler 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

Alta M. 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 W

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

7. Birth date of deceased aug 2 1890  
(Month) (Day) (Year)

8. AGE: Years 36 Months 9 Days \_\_\_\_\_ 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 \_\_\_\_\_

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) 6/23/44 (b) Belle Turner  
(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 may day 21  
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 \_\_\_\_\_

Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—

SUPPLEMENTARY

ETERNAL

18112