DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 12 1944

Registration District No. 320

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21522

Primary Registration District No. 5459

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene Co.

(b) City or town ~~[illegible]~~ Bois D'Arc
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [illegible]
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town (near Bois D'Arc)
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Center
(If rural, give location)

(e) If foreign born, how long in U. S. A.? Nap O years.

3. (a) PRINT FULL NAME Robert Franklin Browne

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

3. (c) Social Security No. .....

4. Sex Male

5. Color or race .....

6. (a) Single, widowed, married, divorced .....

6. (b) Name of husband or wife Francine Browne

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

7. Birth date of deceased October (Month) 4 (Day) 1874 (Year)

8. AGE:

Years	Months	Days	If less than one day
70	8	7	..... hr. ..... min.

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

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name William Browne
13. Birthplace Stone Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Anna [illegible]
15. Birthplace Stone Co (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Burton W Browne

(b) Address Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan (Month) 11 (Day) 1944 (Year)

(c) Place: burial or cremation Rose Hill County

18. (a) Signature of funeral director A S Wallace

(b) Address Billings Mo.

19. (a) June 12 - 1944 (Date received local registrar) (b) Jewell Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 11th. year 1944 hour 2 45 minute 45 P M.

21. I hereby certify that I attended the deceased from ....., 1938, to 6 - 11 —, 1944; that I last saw him alive on 6 - 11 —, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Nephritis	3 yrs.
Due to Cardiac Asthma	2 yrs
Due to —	
Other conditions — (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy none

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) no

(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? ✓ (e) Means of injury ✓

23. Signature B F Windle MD (M. D. or other)

Address Bois D'Arc Mo Date signed 6/12/44

(Licensed Embalmer's Statement on Reverse Side)

12 4-1

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

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.

RECEIVED
Green... County Health Office,
County File Number 44-7-59
Date Filed

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 Oscar Marsh, Registered Apprentice No. ....., working under my personal supervision.

Signed A S Wallace

Licensed Embalmer No. 2175

P. O. Address Billings Mo

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.

. S. No. 2B
0M—5-43
ao I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July VS

Registration District No. 320 Primary Registration District No. 5459 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Green
(b) City or town Bois d'Arc Center 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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Robert F. Brown
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frances
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 4 (Day) 1874 (Year)
8. AGE: Years 70 Months 8 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day
year 1944 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

BUREAU OF CENSUS

1944 JUL 17 PM 1 29

ADMINISTRATIVE SERVICE
DIVISION

21522