

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.

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

27404

Do not use this space.

FILED SEP 13 1944

1. PLACE OF DEATH

(a) County CandlenRegistration District No. 50(b) Township ArgonnePrimary Registration District No. 5176Registered No. 26(c) City Stoutland(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 SARAH Alice Brown(a) Residence, No. St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widow

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

Charley Brown

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

67723

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

house wife

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)

7-31-194411. Total time (years) spent in this occupation all life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Candlen County Mo

FATHER

13. NAME

Robert W. Wray

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

Kentucky

MOTHER

15. MAIDEN NAME

Catharine Leach

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

Candlen County Mo

17. INFORMANT (ADDRESS)

Robert Brown Stoutland Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE High Point Cemetery DATE 8/2

19. FUNERAL DIRECTOR (ADDRESS)

Wingard Evans Stoutland Mo20. FILED Aug 12, 1944Edith Nelson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

Aug 15, 1944

22. I HEREBY CERTIFY, That I attended deceased from

Aug 1st, 1944, to Aug 15th, 1944I last saw her alive on August 13th, 1944. Death is saidto have occurred on the date stated above, at 3:30 p.m.

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

sp. pleeglyCerebral Hemorrhage

Date of onset

8-1-44

Other contributory causes of importance:

hypertension

Name of operation

head & neck

Date of

What test confirmed diagnosis? head & neck Was there an autopsy? no

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

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

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

Manner of injury

Nature of injury

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

If so, specify

(Signed)

C. C. Carter, M. D.(Address) Stoutland Mo

1337

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District

8-44-1254

Date Filed

9-12-44

STATEMENT BY LICENSED EMBALMER

I, Walter Mott Embalmer, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.)