

FILED AUG 16 1944
Registration District No. 298

Primary Registration District No. 4428

Registrar's No. 73

1. PLACE OF DEATH

(a) County Pulaski
(b) City or town Richland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life. (Specify whether
In this community Life. years, months or days)

3. (a) PRINT FULL NAME

OLLIE 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 B. Brown 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Nov 18th 1906 (Month) (Day) (Year)

8. AGE: Years 37 Months 8 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name Edith Phillips
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Wilson
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant B. Brown
(b) Address Richland
17. (a) Burial (b) Date thereof 7-27-44 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director R. B. Turner
(b) Address Richland Mo.
19. (a) 8-1-1944 (b) B. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pulaski
(c) City or town Richland (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 11
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th year 1944 hour 10 minute 0 P.M.
21. I hereby certify that I attended the deceased from 6-18 1944 to 7-24 1944
that I last saw her alive on 7-24 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Uteri
Due to

Due to
Other conditions (Include pregnancy within 3 months of death) 48h

Major findings: Of operations
Of autopsy no

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
23. Signature Dr. R. H. Howard (M.D. or other)
Address Date signed 7-28-44

1170

(Licensed Embalmer's Statement on Reverse Side)

107 3120 611

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

MAR 4 1959

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.