

FILED SEP 28 1944

Registration District No. 376

Primary Registration District No. 6025

Registrar's No. 137

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon 94
(c) City or town Birch Tree
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS BENJAMIN BROWN

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Betty Catherine Martin 6. (c) Age of husband or wife if alive Age Unk years
7. Birth date of deceased April 25, 1871
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 2 If less than one day hr. 0 min.

9. Birthplace Falling Springs, Oregon Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name James Brown
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Minerva Gum
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 6-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Forest Cem. Birch T

18. (e) Signature of funeral director Duncan Funeral Home

(b) Address Mountain View, Mo.

19. (a) Aug 8 1944 (b) J. J. Roberts
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1944 hour 8 minute 05 P. M.

21. I hereby certify that I attended the deceased from June 15, 1944 19____ to June 27, 1944 19____
that I last saw him alive on June 27, 1944 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic
arteriosclerosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy No 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? ee, Mo.

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) 2nd

Address 408 W. Third Date signed 7-7-44

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

RECEIVED

District Health Officer No. 4
District File Number 944-4366
Date Filed 9-26-44

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, or by.....

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

Signed Bert J. Miller
Licensed Embalmer No. 3752
P. O. Address Farmington, Me

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.