

Registration District No. 20/1944

Primary Registration District No. 4330

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town East Prairie  
(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 In County 40 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss. 67  
(c) City or town East Prairie 2  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None 1)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th  
year 1944 hour 7 minute PM M.

21. I hereby certify that I attended the deceased from Oct 1 1944 to Oct 6 1944  
that I last saw him live on head or arrival  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion  
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 [Signature] (M. D. or D. O.)  
Address Wyatt, Mo. Date signed 10-22-44

3. (a) PRINT FULL NAME James F. Brown

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

4. Sex M 0 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cary L. Brown 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased August 30th 1876  
(Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Metropolis Ill. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

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

12. Name Will Brown

13. Birthplace N.K. Ill. 1  
(City, town, or county) (State or foreign country)

14. Maiden name N. K.

15. Birthplace N. K. 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Brown

(b) Address Charleston, Mo. c/o Ford Co.

17. (a) Burial (b) Date thereof 10-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Charleston Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Charleston, Mo.

19. (a) 11-14-1944 (b) Fannie E. Brueman  
(Date received local registrar) (Registrar's signature)

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

7  
2  
0

1271

RECEIVED

District Health Office No. 2,

District File Number 44-1551

Date Filed 11-17-44

**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

*John T. Nunnally Jr.*

Licensed Embalmer No. 3851

P. O. Address

Charleston, 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, fact should be so stated above.**