S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9496

Registration District No. 8D

Primary Registration District No. 3017

Registrar's No. 36

1. PLACE OF DEATH:

(a) County COOPER

(b) City or town BOONVILLE Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 DAYS (Specify whether
In this community 17 DAYS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER 27

(c) City or town BLACKWATER 1
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MRS JULIA SELDON BROWN

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race NEGRO

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

6. (b) Name of husband or wife

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

7. Birth date of deceased FEBRUARY (Month) 20 (Day) 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
78	0	22	hr. min.

9. Birthplace SALINE COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name TAYLOR GAILS
13. Birthplace SALINE COUNTY (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace ✓ (City, town, or county) ✓ (State or foreign country)

16. (a) Informant FIELDEN BROWN
(b) Address ST. LOUIS, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 18, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation SAPPINGTON CEMETERY

18. (a) Signature of funeral director STEGNER & KOENIG
(b) Address BOONVILLE, MO.

19. (a) Mar-16-45 (Date received local registrar) (b) Dr. Chas. Swap. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 14th
year 1945 hour 8:50 minute a.M.

21. I hereby certify that I attended the deceased from Feb. 24 1945 to Mar 13, 1945
that I last saw her alive on Mar 13 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Nephritis, chronic interstitial	yrs.
Due to Arterial hypertension	5 yrs
Due to chronic myocarditis	?
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None 131a
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)
(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 other) MD
Address Boonville, Mo Date signed 3/14/45

1088

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4/5/45

492

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 James W Stegner

Licensed Embalmer No. 3780

P. O. Address Boonville, 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.