Form 2
—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 28 1945

Registration District No. 741

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5551

State File No. 20456

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: 1 Howell Sup
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 5 hrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell

(c) City or town Olden 46
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Peggy Ann Brower

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased 6/3 - 1945
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. $ ..... min.

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

10. Usual occupation Infant

11. Industry or business .....

FATHER
12. Name Lee Henry Brower
13. Birthplace Olden, Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dorothy Van Uhrle
15. Birthplace Ravenden Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant L. H. Brower
(b) Address Olden, Mo.

17. (a) B (Burial, cremation, or removal) (b) Date thereof 6/4-45
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion

18. (a) Signature of funeral director Robertson
(b) Address West Plains, Mo.

19. (a) 6/20-45 (Date received local registrar) (b) Dave Harlin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from June 3, 1945, to June 3, 1945, that I last saw her alive on June 3, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac - Disease	4 hrs
Due to Valve failed to close	
Due to 95C2	
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 A. H. Thornburgh (M. D. or other)
Address West Plains, Mo. Date signed 6/18/45

1128

(Licensed Embalmer's Statement on Reverse Side) Thornburgh

RECEIVED
District Health Officer No. 5,
District File Number 645-302
Date Filed 6-27-45

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.

2B
-3-45
1-X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 141 Primary Registration District No. 1557 Registrar's No. 8

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Rural
(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 ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell

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

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

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

If yes, name country .....

3. (a) PRINT FULL NAME Peggy S. Brower

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased June (Month) 3 (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

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

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 8
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

S-20456