

**FILED** NOV 1 1945

Registration District No. 163

Primary Registration District No. 3031

1. PLACE OF DEATH:

(a) County Jefferson  
(b) City or town Delato  
(c) Name of hospital or institution: St. Charles  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 75 days  
In this community 75 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jefferson  
(c) City or town Delato  
(d) Street No. 708 E Miller St  
(e) Citizen of foreign country? no  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PHOEBE CATHERINE BROWN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W  
6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife JOHN BROWN  
6. (c) Age of husband or wife if alive 9 years  
7. Birth date of deceased Sept 9 1868  
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 3  
If less than one day hr. min.

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

10. Usual occupation at home

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

12. Name Sage Tinsler  
13. Birthplace Jefferson Co Mo  
14. Maiden name Margaret Pater  
15. Birthplace Jefferson Co Mo

16. (a) Informant Phoebe Brown  
(b) Address Delato Mo

17. (a) Burial (b) Date thereof Oct 12 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Cemetery RR. Delato

18. (a) Signature of funeral director Lowell B. ...  
(b) Address Delato Mo

19. (a) 10-20-45 (b) Fern Spencer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10  
year 1945 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 14  
1945 to Oct 10 1945  
that I last saw her alive on Oct 9 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations Phy  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(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 2

23. Signature Clarence A. ...  
Address Delato, Mo Date signed Oct 12/45

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 9;

District File Number \_\_\_\_\_

Date Filed 10-31-45

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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. 4104

P. O. Address Detroit, Mich.

**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.**