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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34490**  
Registrar's No. **197**

**FILED NOV 8 1945**  
Registration District No. **316**

Primary Registration District No. **3059**

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

**1. PLACE OF DEATH:**

(a) County St. Francois

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

(c) Name of hospital or institution: Bonne Terre Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

In this community 25 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Francois

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

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

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Anna Brown

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

4. Sex  Male /  Female / race W

5. Color or \_\_\_\_\_ 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Nolan Brewster Brown 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Nov 13 1867  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 10 day 27  
year 45 hour 4 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10-15 to 10-22 1945  
that I last saw her alive on 10-22 1945  
and that death occurred on the date and hour stated above.

**8. AGE:** Years 77 Months 11 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation housewife

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

**MOTHER FATHER** { 12. Name Henry Eccert

{ 13. Birthplace Baltimore Maryland  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Koch

{ 15. Birthplace Waterloo Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Nolan Brown

(b) Address Farlington, Mo.

17. (a) b (b) Date thereof 10-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary of St. Louis

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farlington, Missouri

19. (a) 10-23-45 (b) Ether Kidloff  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Pneumonia

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

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

Other conditions (In case of death in hospital or institution)

Major findings: Of operations \_\_\_\_\_

Of autopsy 10/

**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? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

23. Signature W. G. Galle (M. D. or other) \_\_\_\_\_  
Address Wesley, Mo. Date signed 10-27-45

1397

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 114-S-1293

Date Filed 11-8-45

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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..... *A. Ocean* .....

Licensed Embalmer No. 4084

P. O. Address Farmington, 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.