

FILED DEC 7 1945

Registration District No. 36

Primary Registration District No. 4048

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Rocheport Mo.
(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 years, months or days)
In this community 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Rocheport
(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 Linda Jane Garrett Brown

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Mort Brown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 12, 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Fort Royal Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name James Garrett
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Mary Triplett
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Earnest Brown
(b) Address Rocheport Missouri

17. (a) Burial (b) Date thereof 9/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rocheport Cemetery

18. (a) Signature of funeral director Ralph A. Carr
(b) Address Fayette, Missouri

19. (a) 10/13/45 (b) MRS. W. H. ANGELL
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25
year 1945 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec - 2 - 1945 to Sept 25th 1945
that I last saw him alive on Sept 6 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
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? _____ (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) (e) Means of injury _____
23. Signature H. E. Russell (M. D. or other) _____
Address Rocheport Mo Date signed 9-27-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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, only
....., Registered Apprentice No.
working under my personal supervision.

Signed Ralph A. Carr
Licensed Embalmer No. 3340
P. O. Address Lyette 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.