

FILED JAN 11 1946
141

Registration District No. **141**

Primary Registration District No. **3025**

1. PLACE OF DEATH:

(a) County **Hawell**
(b) City or town **West Plains**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Christa Hogan Hospital**
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **2 days** (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Hawell**
(c) City or town **Olden**
(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 **Cecil Henry Brower**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife **Dorothy Brower** 6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **4-10-1915**
(Month) (Day) (Year)

8. AGE: Years **30** Months **8** Days **4** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farming**

11. Industry or business _____

MOTHER FATHER
12. Name **Arch Brower**
13. Birthplace **Olden Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Ella Graham**
15. Birthplace **Olden Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. C.H. Brower**

(b) Address **B Olden, Mo.**

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof **12-16-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Zion**

18. (a) Signature of funeral director **Robertson**

(b) Address **West Plains, Mo.**

19. (a) **Jan. 4 1946** (b) **Bludys Harrison**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **14**
year **1945** hour **2** minute **10** P.M.

21. I hereby certify that I attended the deceased from **Dec. 9, 1945** to **Dec. 14, 1945**,
that I last saw him alive on **Dec. 14, 1945**,
and that death occurred on the date and hour stated above.
Immediate cause of death **Infection, Blood stream.**

Duration **6** das.

Due to **Infected by bite of hog in left thigh.**

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 **A. H. Thornburgh** (M. D. or D. O.)

Address **West Plains, Mo.** Date signed **12/17/45**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1514

(Licensed Embalmer's Statement on Reverse Side)

Thornburgh

RECEIVED

District Health Officer No. 5.

District File Number 14573

Date Filed 11/9/46

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. 3437

P. O. Address West Plains, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Law
Registrar's No. 135

Registration District No. 141

Primary Registration District No. 3025

1. PLACE OF DEATH:
(a) County Haskell
(b) City or town West Plains
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Cecil D. Brower
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 10, 1917
(Month) (Day) (Year)

8. AGE: Years 30 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration: _____
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) Accident
(b) Date of occurrence Dec. 9, 1945
(c) Where did injury occur? Olden, Howell, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In woods, near his home
While at work? Yes (Specify type of place) (e) Means of injury Was attacked
by a wild hog.
23. Signature Ad. [unclear] M.D. (M. D. or other) M.D.
Address West Plains, Mo Date signed 1/14/45

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

17528
19

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

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

MOTHER FATHER

41353