

No. 2  
5-43  
17-39  
X36871

FILED JAN 24 1946

Registration District No. 14 Primary Registration District No. 3038 Registrar's No. 614

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
328 E. Robard St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 60 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Linn 58

(c) City or town Brookfield 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 328 E. Robard 2  
(If rural, give location) 0

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN ERWIN

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

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

4. Sex Mo 5. Color or race W

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

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

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

7. Birth date of deceased Aug - 2 - 1896  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 4 11 hr. min.

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

10. Usual occupation Ret Farmer

MOTHER, FATHER

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

12. Name Stephenson Brown

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

14. Maiden name Emma Applegate

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

16. (a) Informant Mrs Irma M. Kemie

(b) Address Brookfield, Mo

17. (a) Burial (b) Date thereof Dec-15-1945  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield Mo

19. (a) 12/15/45 (b) Embry Kelly, Deputy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec day 13  
year 1945 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from Mar, 1940 to 12-13-1945  
that I last saw him alive on Dec, 7, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis 1 yr.  
toxic goiter (many years)

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

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

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

Major findings:  
Of operations 93d

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? \_\_\_\_\_

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

(2) Means of injury 2 DD

23. Signature W. B. Simpson (M. D. or other)

Address Brookfield, Mo Date signed 12/14/46

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

RECEIVED

District Health Officer No. 11,

District File Number

Date Filled

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

*J. R. Blacklock*

Licensed Embalmer No.

*2246*

P. O. Address

*Brookfield Ma*

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.