No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

41784

State File No.

FILED JAN 8 1946

Registration District No. 2

Primary Registration District No. 3042

Registrar's No. 81

1. PLACE OF DEATH:

(a) County Madison

(b) City or town Fredericktown
(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 LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison 62

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

(d) Street No. 404 Lindell /
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME Celia Ann Brown

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife John W Brown

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Nov (Month) 17 (Day) 1870 (Year)

8. AGE: Years 75 Months 1 Days 1 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Poor
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ✓
15. Birthplace ✓ (City, town, or county) (State or foreign country)

16. (a) Informant Mary Miller
(b) Address Fredericktown Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation New Masonic - Fredericktown

18. (a) Signature of funeral director Webb & Holt
(b) Address Fredericktown Mo.

19. (a) 12-19-45 (Date received local registrar) (b) Florence Hicks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18
year 1945 hour 11:40 minute A. M.

21. I hereby certify that I attended the deceased from Dec 15, 1945, to Dec 18, 1945
that I last saw her alive on Dec 17, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Glomerular Nephritis	about 10 yrs
Influenza Dec 14-1945	4 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature C W Delgene (M. D. or other) DO.
Address Fredericktown Mo Date signed 12-19-45

1566 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 146-1468

Date Filed 1-5-46

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 John H. Holt

Licensed Embalmer No. 4264

P. O. Address Fredericktown 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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 206 Primary Registration District No. 3042 Registrar's No. 81

1. PLACE OF DEATH:

(a) County Madison

(b) City or town Fredericktown
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. 404 Pindell
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Celia A. Brown

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Nov 17, 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

41784