

no. 2  
17-39  
X38671

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

**FILED FEB 15 1946**

Registration District No. 184 Primary Registration District No. 303-25687 Registrar's No. 4

**1. PLACE OF DEATH:**  
 (a) County Linn  
 (b) City or town Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Rural 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 43 years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Linn 58  
 (c) City or town Rural  
 (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** CLYDE ATWOOD BROWN

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

4. Sex Mo 5. Color or race W 6. (a) Single, widowed, married, divorced M

(b) Name of husband or wife Mary May Brown 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased May-26-1881  
(Month) (Day) (Year)

8. AGE: Years 64 Months 7 Days 8 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Chief Clerk

11. Industry or business R.R.

12. Name Sewell Franklin Brown

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

14. Maiden name Phoebe Obier

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

16. (a) Informant Agnes C. Brown  
(b) Address Reveries, Missouri

17. (a) Burial (b) Date thereof Jan-5-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Hill Funeral Home

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

19. (a) 1-5-46 (b) Everly Kelly, Deputy  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 3  
year 1946 hour 11 minute 35 AM

21. I hereby certify that I attended the deceased from 11-1 1946 to 1-3 1946  
that I last saw him alive on 1-3 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Acute Rheumatism and Myocarditis  
(Arterial)

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

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

Major findings: Of operations None  
Of autopsy None

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 C. E. Enoch (M. D. or other)  
Address Brookfield, Mo Date signed 1-4-46

Duration

None

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

PHYSICIAN

Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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

working under my personal supervision.

Registered Apprentice No.

Signed

J. H. Blacklock

Licensed Embalmer No.

2246

P. O. Address

Brookfield 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.

Registration District No. 184

Primary Registration District No. 5687

Registrar's No. x

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Rural Brookfield Twp  
(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 \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

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

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 \_\_\_\_\_

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

7. Birth date of deceased May 26 1906  
(Month) (Day) (Year)

8. AGE: Years 64 Months 7 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 Feb Day 13 Year 1946 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 \_\_\_\_\_

Due to cholesterol inf. atherosclerosis

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

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy 13/a

Duration

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

1500 USE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

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