

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5355**

Registration District No. **123**

Primary Registration District No. **3022**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **Harrison**
(b) City or town **Bethany**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Reid Hosp. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **24 hrs**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **Lois Lucille 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 **Married**
6. (b) Name of husband or wife **Charles**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 4 - 1906**
(Month) (Day) (Year)

8. AGE: Years **39** Months **7** Days **27**
If less than one day hr. min.

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

10. Usual occupation **House wife**

11. Industry or business

12. Name **Louise Clark**

13. Birthplace **Ky** **I**
(City, town, or county) (State or foreign country)

14. Maiden name **Lena Barker**

15. Birthplace **Mo** **O**
(City, town, or county) (State or foreign country)

16. (a) Informant **Geo Clark**
(b) Address **Winstan Mo.**

17. (a) **Removal** (b) Date thereof **2-3-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **Crestwood Cem.**

18. (a) Signature of funeral director **Mrs Kate Group**
(b) Address **Winstan Mo.**

19. (a) **Feb 4 - 46** (b) **zola Burris**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Daviess**
(c) City or town **Pattonsburg**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **1**
year **1946** hour **6 P M** minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 20**, 19**46**, to **Jan 28**, 19**46**,
that I last saw h **e** alive on **June 28**, 19**46**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxia and Malnutrition**

Due to **Mental Confusion Refusal to Eat**

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?

While at work? _____ (Specify type of place) (c) Means of injury **0**
23. Signature **John Barker** (M. D. or other)
Address **Pattonsburg** Date signed **Feb 11/46**

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

4351

116

MAY 27 1948

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.....

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

Signed *L. O. Richman*

Licensed Embalmer No. *3302*

P. O. Address *Salisbury, 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.