

S. No. 2
M-2-43
5-17-39
P1 X35697

Dr. E. H. Cape

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8979

FILED APR 15 1946

Registration District No. _____ Primary Registration District No. 4175 Registrar's No. 6

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Homer
(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 27 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Homer
(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 George Stilly Brown
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 19 year 1946 hour 7 minute 10 P.M.
21. I hereby certify that I attended the deceased from Sept 1945 to Mar 19 1946
that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Ind Brown 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased: July 12 1867 (Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis
Due to AT TACKLE
Duration 1 yr
Due to AT TACKLE
Duration 1 yr

8. AGE: 79 Years 8 Months 6 Days If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____ Of autopsy 93d

9. Birthplace Hayden Indiana
10. Usual occupation part master
11. Industry or business retired
12. Name Allen Brown
13. Birthplace (City, town, or county) (State or foreign country) Indiana
14. Maiden name unknown
15. Birthplace (City, town, or county) (State or foreign country) Ind

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

MOTHER FATHER {
16. (a) Informant Inda Brown
(b) Address Homer, Mo.
17. (a) Removal & Burial (b) Date thereof 3 20 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Little Prairie Emburser
18. (a) Signature of funeral director Paterson
(b) Address Cynthiana, Missouri
19. (a) 3-21-46 (b) Bertha Rauschberg (Date received local registrar) (Registrar's signature)

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 J. H. Rose (M. D. or other) _____
Address Homer, Mo. Date signed 3/29/46

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

35
0
0

35
0
0

36

RECEIVED

District Health Office No. 2,

District File Number 446-511

Date Filed 4-10-46

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 Noel C. Dean.....

Licensed Embalmer No. 3941.....

P. O. Address Conithsville.....

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.