

FILED JUL 16 1946

Registration District No. _____ Primary Registration District No. **50235597** Registrar's No. **45**

1. PLACE OF DEATH:

(a) County **Jefferson**

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

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jefferson** **50**

(c) City or town **Rural** (If outside city or town limits, write "RURAL") **0**

(d) Street No. **R. 2** **Erastus** (If rural, give location) **0**

(e) Citizen of foreign country? _____ (Yes or No) **0**

If yes, name country _____

3. (a) PRINT FULL NAME **Erastus J. Brown**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Ella Brown**

6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **July 24 1874** (Month) (Day) (Year)

8. AGE: Years **71** Months **10** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown** (City, town, county) (State or foreign country) **1**

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Jack Brown**

(b) Address **Erastus mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6-9-46** (Month) (Day) (Year)

(c) Place: burial or cremation **Parby mo.**

18. (a) Signature of funeral director **Frank Hud co.**

(b) Address **Erastus mo**

19. (a) **June 26 1946** (Date received local registrar) (b) **Erastus Brown** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **7** year **1946** hour **3** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **January 14**, 19**44**, to **June 7**, 19**46** that I last saw him alive on **June 7**, 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of the eye ball, orbits and face**

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **Berlata Bilgual** (M. D. or other) **0**

Address **Erastus mo** Date signed **6/13/46**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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

Ellicar Prounce

Licensed Embalmer No.

3 fo 3

P. O. Address

Festus 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 45

Registration District No. 160 Primary Registration District No. 5592

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Rural
(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

3. (a) PRINT FULL NAME Erastus J. 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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased July 24
(Month) (Day) (Year)

8. AGE: Years 71 Months 12 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____
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 Cancer of the forehead, white eye and nose (primary)

Due to _____

Due to 53

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

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