

**FILED JUL 25 1946**  
Registration District No. **4516**

Primary Registration District No. **4516**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County **Laney, Mo**  
 (b) City or town **Fansyth, Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Sons Home!**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community **all of life** \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Laney**  
 (c) City or town **Fansyth**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **Rural**  
(If rural, give location)  
 (e) Citizen of foreign country? **U.S.A** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Reaper, May Brown**  
 3. (b) If veteran, name war **no**  
 3. (c) Social Security No. **no**

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **April** day **16**  
 year **1946** hour **3** min **45** A.M.

**21. I hereby certify that I attended the deceased from** **March 20**  
**1946** **to** **April 16** **1946**  
 that I last saw her alive on **April 16** **1946**  
 and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **Widow**  
 6. (b) Name of husband or wife **none**  
 6. (c) Age of husband or wife if alive **no** years  
 7. Birth date of deceased **Nov 24 66**  
(Month) (Day) (Year)

Immediate cause of death **Lobar Pneumonia** **3 weeks**  
 Duration \_\_\_\_\_

**8. AGE:** Years **80** Months \_\_\_\_\_ Days \_\_\_\_\_  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions **Cardiac Athma**  
(Include pregnancy within 3 months of death)

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

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy **106**

**10. Usual occupation** **House Keeper**  
**11. Industry or business** \_\_\_\_\_  
**12. Name** **Unknap, Blain**  
**13. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Unknap**  
**15. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

**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)  
 Means of injury \_\_\_\_\_  
**23. Signature** **W. Regal** (M. D. or other) \_\_\_\_\_  
 Address **Fansyth, Mo** Date signed **4-17-46**

**16. (a) Informant** **Charles Brown**  
 (b) Address **Fansyth, Mo**  
**17. (a) Place of burial or cremation** **Beier** (b) Date thereof **4-17-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Cedar Creek, Mo**  
**18. (a) Signature of funeral director** **Larry Fansyth**  
 (b) Address **Fansyth, Mo**  
**19. (a) Date received local registrar** **April 17 46** (b) **C. R. Allaman** (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 746-784

Date Filed JUL 24 1946

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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 Minnie S. Whelahan ALBANY

Licensed Embalmer No. 2277

P. O. Address Danvers Me

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. Aug  
Registrar's No. \_\_\_\_\_

Registration District No. 351

Primary Registration District No. 4516

1. PLACE OF DEATH:

(a) County Jamez Joseph  
(b) City or town \_\_\_\_\_  
(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 Reamer M 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 wid

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

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

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

9. Birthplace St. Louis, Mo Ark.  
(City, town, or county) (State or foreign country)

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

11. Industry or business Stitcher

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) JUNE 20-46 (b) C. R. Allaman  
(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 Aug 1946 year. 19 hour 16 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 \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

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

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

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

26000