

FILED SEP 11 1946

Registration District No. 96

Primary Registration District No. 53-56

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Long Lane
(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
In this community 1 year
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Long Lane
(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

JOSEPH MARION BROWN

(b) If veteran, name war

(c) Social Security No.

4. Sex Male

5. Color or hair White

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased

August 18 1860 (Month) (Day) (Year)

8. AGE:

Years 86

Months

Days 3

If less than one day

hr. min.

9. Birthplace

Dallas Mo (City, town, or county) (State or foreign country)

10. Usual occupation

farmer

11. Industry or business

MOTHER FATHER

12. Name

Wm M Brown

13. Birthplace

Mo (City, town, or county) (State or foreign country)

14. Maiden name

Elizabeth

15. Birthplace

Mo (City, town, or county) (State or foreign country)

16. (a) Informant

Miss Alta Brown

(b) Address

Long Lane Mo

17. (a)

Burial (Burial, cremation, or removal)

(b) Date thereof

8-23-46 (Month) (Day) (Year)

(c) Place: burial or cremation

Long Lane

18. (a) Signature of funeral director

B. B. Jones

(b) Address

Buffalo Mo

19. (a)

9-7-46 (Date received by registrar)

(b)

Prace Petras (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1946 hour minute 3:55 A.M.

21. I hereby certify that I attended the deceased from Aug 21 1946 to Aug 20 1946 that I last saw him alive on Aug 20 1946 and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage
Arterio Sclerosis

Duration

5 yrs

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)

(c) Means of injury

23. Signature

O. G. Jamison

(M. D. or other) M.D.

Address

Buffalo Mo

Date signed 9-5-46

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

REC

District

Member No. 7,

Dist.

8-46-935

Date

9-10-46

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

Marie B Jones

Licensed Embalmer No.

4322

P. O. Address

Buffalo, 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.