

FILED SEP 14 1948

Registration District No. **78**

Primary Registration District No. **4555-5368**

Registrar's No. **82**

1. PLACE OF DEATH:
(a) County **Daviess Coffey**
(b) City or town **Coffey**
(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 **12 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Daviess 31**
(c) City or town **Coffey Mo** (If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **15**
year **1946** hour **6** minute **30 P.** M.
21. I hereby certify that I attended the deceased from **May 20**
1946 to **July 15**, 19**46**
(that I last saw him alive on **July 15**, 19**46**
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**
6. (b) Name of husband or wife **Alice Grace Brown**
6. (c) Age of husband or wife if alive. **59** years
7. Birth date of deceased. **Sent** **5** **1883**
(Month) (Day) (Year)

Immediate cause of death
Carcinoma of bladder and ureter
Duration **6 mo**

8. AGE: Years Months Days If less than one day
62 **10** **10** hr. min.

Due to
Due to
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

9. Birthplace. **Dekalb Co Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation. **Farmer**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business
12. Name. **Thomas Brown**
13. Birthplace. **Mo**
(City, town, or county) (State or foreign country)
14. Maiden name. **Susanna Butler**
15. Birthplace. **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant. **Mrs Alice Brown**
(b) Address. **Coffey, Mo**

17. (a) Burial (b) Date thereof **7/17/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **King City, Mo**

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 **2**

18. (a) Signature of funeral director. **Shoemaker**
(b) Address. **Pattonburg, Mo**
8-17-46 (c) **Dugueson Engelhart**
(Date received local registrar) (Registrar's signature)

23. Signature **P. S. Baumgardner** (M. D. or other)
Box 88 Coffey Mo Date signed **7/15/46**

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

397

Paul
Bourgeois

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 *E. Schomer*

Licensed Embalmer No..... 2857

P. O. Address..... Pattonsburg, 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.

2B
45
43882

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 9-8

Primary Registration District No. 5368

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Davies
(b) City or town Coffey
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Austin W. 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 Sept 5 (Month) (Day) (Year)

8. AGE: Years 62 Months 10 Day 10 (If less than one day) hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo had involved the rectum

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

Carcinoma of bladder on posterior superior surface at termination it also involved the rectum

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 P. Baumgardner (M.D. or other) 400
Address Coffey Mo Date signed 7/14/46

SUPPLEMENTARY

20714