

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41227
Registrar's No. 228

FILED DEC 23 1946

Registration District No. 187 Primary Registration District No. 3038

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

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: McLarney Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 38 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Brookfield
(If outside city or town limits, write "RURAL")

(d) Street No. 1125 North Main
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Margaret Brownfield

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife Dr. S. T. Brownfield

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased August 7, 1873
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Benjamin Brownfield

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

14. Maiden name Mary Super

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

16. (a) Informant Dr. S. T. Brownfield

(b) Address Brookfield, Mo.

17. (a) Burial (b) Date thereof Dec. 9, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Rusk Funeral Home

(b) Address Brookfield, Mo.

19. (a) 1/9/46 (b) W. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7 year 1946 hour 1 minute 15 a. M.

21. I hereby certify that I attended the deceased from 1/6 1945 to Dec 7 1946
that I last saw her alive on Dec 7 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Ascending Colon (K.M.O.)

Due to _____

Due to _____

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

Major findings: 46E

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 W. Brown (M. D. or other) NO

Address Brookfield Mo Date signed 12/7/46

400739

169

DISTRICT HEALTH OFFICE
Cameron, Mo.

JUL 22 1957

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..... *Harold B. Wright*

Licensed Embalmer No..... 3718

P. O. Address..... Brookfield, 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.