

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
2000

Dr. Schwab 4548
State File No. _____
Registrar's No. 122

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH: GREENE
(a) County: Springfield
(b) City or town: Springfield
(c) Name of hospital or institution: Burge Hospital
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Greene 39
(c) City or town: Springfield - RUTAC
(d) Street No.: 2515 W. Lincoln
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME: Sandra Faye Brown
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 9th year 1947 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from 2-7-47, 19, to 2-9-47, 19, that I last saw her alive on 2-9-47, 19, and that death occurred on the date and hour stated above.

4. Sex: F | 5. Color or race: W | 6. (a) Single, widowed, married, divorced: 0
6. (b) Name of husband or wife: _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Feb 6 1947 (Month) (Day) (Year)

Immediate cause of death: Erythroblastosis fetalis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy: Same

8. AGE: Years Months Days If less than one day
3 hr. min.

9. Birthplace: Springfield Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Infant

11. Industry or business _____

12. Name: John O. Brown
13. Birthplace: Springfield Mo. (City, town, or county) (State or foreign country)
14. Maiden name: Bernadine Blaypool
15. Birthplace: Springfield Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: John O. Brown
(b) Address: 2515 W. Lincoln
17. (a) Burial, cremation, or removal: Burial
(b) Date thereof: 2-10-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Springfield Mo.

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

18. (a) Signature of funeral director: W. H. Damm
(b) Address: Springfield Mo.
19. (a) 2-12-47 (Date received local registrar)
(b) W. E. Handley M.D. (Registrar's signature)

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: E. J. Schwab (M. D. or other)
Address: 420 Third Ave Bldg. Springfield Date signed: 2-10-47

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.....

Licensed Embalmer No.....

P. O. Address.....

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.