

No. 2
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5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 7 1947

Registration District No. 122

Primary Registration District No. 42017

Registrar's No. 10

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Medical Arts Building
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic

(c) Name of hospital or institution
Rural Route
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 20 years
years, months or days

3. (a) PRINT FULL NAME ALFRED TENNYSON BROWN

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Callie B. Brown

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

7. Birth date of deceased July 6, 1874
(Month) (Day) (Year)

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

72	7	20	hr. min.
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9. Birthplace Unknown
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Funeral Director

11. Industry or business Funeral Profession

12. Name Moses Brown

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

14. Maiden name Cynthia Bills

15. Birthplace Unknown, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Callie B. Brown

(b) Address Republic, Missouri

17. (a) Removal (b) Date thereof 2/26/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oklahoma City, Oklahoma

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 2-26-47 (b) Glennie Britton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. Rural Route
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26,
year 1947 hour 3: minute 45 A. M.

21. I hereby certify that I attended the deceased from 23 April
1945, to 26 Feb. 1947

that I last saw him alive on 24 Feb 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Unretractile Duration _____

Due to carcinoma
urinary bladder 2yo

Due to _____

Other conditions chronic Myocarditis
(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? _____

(e) While at work? _____ (Specify type of place)

(f) Means of injury _____

23. Signature [Signature] (M. D. or D. O.) _____
Address 553 1/2 Main St Date signed 26 Feb 1947

PROCESSED
Clerk of the Health Office,
County File No. 47-3-29
Date Filed 3-5-47

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 Julian R. Goodwin, Registered Apprentice No. 423 working under my personal supervision.

Signed Jewell E. Kuddle
Licensed Embalmer No. 2831
P. O. Address Springfield 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.