

FILED DEC 22 1947
Registration District No. **103**

Primary Registration District No. **5685**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Jackson Twp. Rural
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn **58**

(c) City or town Jackson Twp. (Rural) **0**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? No (Yes or No) **0**

If yes, name country _____

3. (a) PRINT FULL NAME Barbara Brown

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2nd
year 1947 hour 10:35 minute a. M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife XXXXXXXX

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

7. Birth date of deceased October 6 1947
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7 Nov. **1947**, to Dec 2 **1947**;
that I last saw her alive on Dec 1 **1947**;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>1</u>	<u>26</u>	hr. _____ min. _____

Immediate cause of death Sarcoma (concentrated) of neck with generalized metastases

Due to _____

Due to _____

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

10. Usual occupation XXXXXX

11. Industry or business XXXXXX

Other conditions 55 F
(Include pregnancy within 3 months of death)

Major findings: Excision of growth
Of operations with finding sarcoma

Of autopsy none

MOTHER FATHER

12. Name Raymond Brown

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

14. Maiden name Mary Powell

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Raymond Brown

(b) Address Linneus, Missouri

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 12/3/1947
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Thorne Undt, Co.

(b) Address Linneus, Mo. (Rt. 1, box 10)

19. (a) Dec. 9, 1947 (Date received local registrar)

(b) Evela Crookshaw (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? 0

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature John R. Dyer (M. D. or other) **MD**
Address Frankford Date signed 12-4-47

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

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.....

was not embalmed....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Dave A. Taylor*.....

Licensed Embalmer No..... *3761*.....

P. O. Address..... *Pinneus, 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.