No. 2
—1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 11 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1633

Registration District No. 170 | Primary Registration District No. 5677 | Registrar's No. 2

1. PLACE OF DEATH:
(a) County: Laclede
(b) City or town: Competition 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 years, months or days)
In this community: Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Laclede 53
(c) City or town: Competition 0
(If outside city or town limits, write "RURAL")
(d) Street No.: Rural Route 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Henry ALLen 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: Married
6. (b) Name of husband or wife: Mary Brown
6. (c) Age of husband or wife if alive: 72 years
7. Birth date of deceased: Nov. (Month) 23 (Day) 1871 (Year)

8. AGE: Years	Months	Days	If less than one day
76	1	27	..... hr. ..... min.

9. Birthplace: Kentucky (City, town, or county) / (State or foreign country)
10. Usual occupation: Retired farmer
11. Industry or business .....
FATHER
12. Name: Belfield Brown /
13. Birthplace: Kentucky (City, town, or county) / (State or foreign country)
MOTHER
14. Maiden name: Sarah Sullivan
15. Birthplace: Kentucky (City, town, or county) / (State or foreign country)
16. (a) Informant: Floyd Brown (Son)
(b) Address: Competition Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-21-48 (Month) (Day) (Year)
(c) Place: burial or cremation: McBride
18. (a) Signature of funeral director: W. E. Holman
(b) Address: Lebanon Mo.
19. (a) 2-7-48 (Date received local registrar) (b) Tressie B Lynch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20 year 1948 hour 9 minute 40 A.M.
21. I hereby certify that I attended the deceased from Jan 17 1948 to Jan 20 1948 and that I last saw him alive on Jan 19 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	2 days
Due to: Cardio-vascular-Renal Disease	years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature: J. E. Worthey M.D. (M. D. or other)
Address: Hartville Mo. Date signed 1-23-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Received 2/10/48
[illegible] County Health Unit
1-48-10
Date filed 2/10/48

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 No Embalming, 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.

No. 2B
—3-45
I X43880

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. Feb

Registration District No. 170 Primary Registration District No. 5627 Registrar's No. 2

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town 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 (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

3. (a) PRINT FULL NAME Henry A. 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 years

7. Birth date of deceased Nov. (Month) 2 (Day) 18 (Year)

8. AGE: Years 76 Months 1 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 2/7/48 (Date received local registrar) (b) Tressie B Lynly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 20
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-1633