FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 12 1948

Registration District No. 7

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4248 3028

State File No. 23272

Registrar's No. 178

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

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 7 Days (Specify whether years, months or days)
In this community: Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper 49
(c) City or town: "Rural" Carthage
(If outside city or town limits, write "RURAL")
(d) Street No.: Route #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: None

3. (a) PRINT FULL NAME: Harriet Agnes BROWN
3. (b) If veteran, name war: No
3. (c) Social Security No.: None

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Sigel Brown
6. (c) Age of husband or wife if alive: 85 years
7. Birth date of deceased: April 26, 1868 (Month) (Day) (Year)

8. AGE: Years 80 | Months 3 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace: Jasper County, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Calvary Chapman
13. Birthplace: Unknown W. Va. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary Jane Paine
15. Birthplace: Unknown W. Va. (City, town, or county) (State or foreign country)

16. (a) Informant: Mr. Sigel Brown
(b) Address: Route #1 Carthage, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-3-48 (Month) (Day) (Year)
(c) Place: burial or cremation: New Hope Cemetery
18. (a) Signature of funeral director: Ed. C. Ulmer
(b) Address: Carthage, Mo.
19. (a) Aug 4 1948 (Date received by local registrar) (b) L. B. Clinton M.D. by H.J. (Registrar's signature)
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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st. year 1948 hour 2:35 minute P.M.

21. I hereby certify that I attended the deceased from July 23, 1948, to July 31, 1948; that I last saw her alive on July 31, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	30 Minutes
Due to:	
Due to:	
Other conditions: Hypostatic pneumonia (Include pregnancy within 3 months of death)	1 wk
Fracture left hip	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause of death which should be used statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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: 0

23. Signature: H E Byrd MD (M. D. or other)
Address: Carthage Mo Date signed: 4 Aug 48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

48-7-677

SEP 6 1950

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 Gene. C. Pugh.

Gene. C. Pugh.

Licensed Embalmer No. 4231

P. O. Address Carthage, 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.

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. aug

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 179

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(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

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 Harriet A. Brown

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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

7. Birth date of deceased April 26 1868
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 3, year 1948 hour minute M.

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

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (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) Death not due to external causes
(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 H E Byrd MD (M. D. or other)
Address Carthage, Mo Date signed Jan 16 48

SUPPLEMENTARY

S-23272