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 AUG 23 1948

Registration District No. 128

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 25946

Registrar's No. 677

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 days (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield, 2
(If outside city or town limits, write "RURAL")

(d) Street No. 901 E. Grand 6
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frances Brownfield

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife George W. Brownfield

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

7. Birth date of deceased June (Month) 7, (Day) 1865 (Year)

8. AGE: Years 83 Months 2 Days 8 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business In Home

FATHER
12. Name Henry Carroll
13. Birthplace Bowling Green, (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Mary Ann Cheek
15. Birthplace Unknown (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant Miss Eunice Brownfield,
(b) Address Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Gorman-Scharpf Funeral Home
(b) Address Springfield, Missouri

19. (a) 8-18-48 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15, year 1948 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from March 30, 1948 to August 15, 1948; that I last saw her alive on August 14, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Thrombosis	5 days
Due to Arteriosclerosis	
Due to	
Other conditions Broken left hip. (Include pregnancy within 3 months of death)	5 wks

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 133 (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. P. Maddux (M. D. or other)

Address Springfield, Mo. Date signed 8/16/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 L Doolin Forman

Licensed Embalmer No. 3177

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.

No. 2B
3-45
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. Sept

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 677

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield (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 France Bromfield
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased June 7 (Month) (Day) 1865 (Year)
8. AGE: Years 83 Months 2 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
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER 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
(b) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 15 year 1948 hour 8:00 minute A. M.
21. I hereby certify that I attended the deceased from March 30, 1948 to August 15, 1948; that I last saw her alive on August 14, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Thrombosis	5 da.
Due to: Arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Broken left hip	5 wks.

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) Accident
(b) Date of occurrence July 17, 1948
(c) Where did injury occur? Home 901 E. Grand (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home — going to bathroom (Specify type of place)
While at work? No (e) Means of injury Fall.
23. Signature H. P. Moody (M. D. or other)
Address Springfield, Missouri Date signed 8/28/48

S-25946 1948