No. 2
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17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26013

FILED AUG 31 1948

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 674

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

1. PLACE OF DEATH:

(a) County GREENE Rural—South Campbell Twp.

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

(c) Name of hospital or institution OZARK OSTEOPATHIC HOSPITAL 0

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53

(c) City or town Conway 0

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

(d) Street No. x 0

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Baby Ira Maynard Brown

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced no

6. (b) Name of husband or wife no

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

7. Birth date of deceased May (Month) 21, (Day) 1948 (Year)

8. AGE: Years no | Months 3 | Days no | If less than one day x hr. x min.

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

10. Usual occupation xxxx

11. Industry or business xxxxx

FATHER

12. Name Robert M. Brown

13. Birthplace Webster County, Mo. (City, town, or county) (State or foreign country) 0

MOTHER

14. Maiden name Katherine E. Wilkerson

15. Birthplace Texas. (City, town, or county) (State or foreign country) 1

16. (a) Informant Robert M. Brown

(b) Address Conway, Mo.

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8-22-48 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ Harmony

18. (a) Signature of funeral director Lex Rainey

(b) Address Marshfield, Missouri

19. (a) 8-25-48 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature) 111 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21 year 1948 hour 01 minute 12 P.M.

21. I hereby certify that I attended the deceased from 8-20-48, 19..., to 8-21-48, 19...; that I last saw him alive on 8-21-48, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

107

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 N. J. Newell (M. D. or other) D.O.

Address 700 E. Sunshine, Springfield, Mo. Date signed 8/21/48

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 Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.