

No. 300  
10-47  
17-39  
I 3906

FILED DEC 30 1948  
Registration District No. 108

Primary Registration District No. 4179

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

1. PLACE OF DEATH:

(a) County: Franklin Salem

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: none  
(Specify whether)

In this community: 60 yrs  
(years, months or days)

3: (a) PRINT FULL NAME: James Oliver Brown

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: male 5. Color or race: W

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

6. (b) Name of husband or wife: Yelma Brown

6. (c) Age of husband or wife if alive: 56 years

7. Birth date of deceased: Sept 9 1892  
(Month) (Day) (Year)

8. AGE: Years: 76 Months: 3 Days: 2  
If less than one day: hr. min.

9. Birthplace: Adair Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation: mechanic

MOTHER FATHER

11. Industry or business

12. Name: Went Kerece 9

13. Birthplace: IL IL  
(City, town, or county) (State or foreign country)

14. Maiden name: W. L. L. 9

15. Birthplace: IL IL  
(City, town, or county) (State or foreign country)

16. (a) Informant: Yelma Brown

(b) Address: Lebanon MO

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 12 48  
(Month) (Day) (Year)

(c) Place: burial or cremation: Lebanon

18. (a) Signature of funeral director: J. J. ...

(b) Address: 12-15-48

19. (a) 12-15-48 (Date received local registrar) (b) W. J. H. Daniel (Registrar's signature) 91

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Franklin 35

(c) City or town: Lebanon MO  
(If outside city or town limits, write "RURAL.")

(d) Street No.: \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 11  
year: 48 hour: 4 minute: 25 AM.

21. I hereby certify that I attended the deceased from Dec 10  
\_\_\_\_\_ 1948 to Dec 11 1948  
that I last saw him alive on Dec 6 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Block Duration: 2 hrs

Due to: Art. circ. coron.

Due to: \_\_\_\_\_

Other conditions: Hypertension 3 years  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations: \_\_\_\_\_

Of autopsy: AM

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? \_\_\_\_\_

While at work? 9 (Specify type of place) Means of injury: 0

23. Signature: George O. ... (M. D. or other) 490  
Address: Lebanon MO Date signed: 12/11/48

RECEIVED

District Health Office No. 2

District File Number 1248-1717

12-27-48

*Arthur Endalmer*

**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 *A. Endalmer*

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.**

S. No. 2B  
FM-3-45  
W 1 X43880

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 29

Registration District No. 108 Primary Registration District No. 4179

1. PLACE OF DEATH:  
(a) County Dunklin  
(b) City or town Senath  
(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 James Oliver CRAVEN  
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 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ 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 \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_

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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

S-39765