

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No.                     

*143*

BIRTH NO.                      REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 20

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>   |  |
| c. LENGTH OF STAY (in this place) <u>6 Days</u>  |  | d. STREET ADDRESS (If rural, give location) <u>310 N. Williams St.</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Boone County Hospital</u>                        |  |  |  |

|                                     |                         |                        |                        |   |
|-------------------------------------|-------------------------|------------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>ADDIE</u> | b. (Middle) <u>MAY</u> | c. (Last) <u>BROWN</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Jan. 14, 1949</u> |
|-------------------------------------|-------------------------|------------------------|------------------------|---|

|                      |                               |   |                                     |   |   |   |
|----------------------|-------------------------------|---|-------------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>May 5, 1879</u> | 9. AGE (In years last birthday) <u>69</u> | # UNDER 1 YEAR<br>Months <u>          </u> Days <u>          </u> | # UNDER 4 HRS.<br>Hours <u>          </u> Mins. <u>          </u> |
|----------------------|-------------------------------|---|-------------------------------------|---|---|---|

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|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>                    </u> | 11. BIRTHPLACE (State or foreign country) <u>Boone County Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
|--|---|--|--|

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|---|---|---|
| 13a. FATHER'S NAME <u>Addison A. Robinson</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah T. Baker</u> | 14. NAME OF HUSBAND OR WIFE <u>James M. Brown</u> |
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|   |   |  |                                     |
|---|---|--|-------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>          </u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Walter Brown, Columbia, Mo.</u> | ADDRESS <u>                    </u> |
|---|---|--|-------------------------------------|

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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  |  | <u>5-6 days</u>                  |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>arterial hypertension</u><br>DUE TO (c) <u>arterio sclerosis, general</u> |  | <u>5 years</u>                   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>331</u>  |  |  |                                  |

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|--|--|---|
| 19a. DATE OF OPERATION <u>                    </u> | 19b. MAJOR FINDINGS OF OPERATION <u>                    </u> | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>                    </u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>                    </u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>                    </u> |
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|   |  |  |
|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>                    </u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>                    </u> |
|---|--|--|

22. I hereby certify that I attended the deceased from Jan 9, 1949, to Jan 13, 1949, that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

|   |   |                                   |                                      |
|---|---|-----------------------------------|--------------------------------------|
| 23a. SIGNATURE <u>Maurice E. Cooper, M.D.</u> | (Degree or title) <u>                    </u> | 23b. ADDRESS <u>Columbia, Mo.</u> | 23c. DATE SIGNED <u>Jan 15, 1949</u> |
|---|---|-----------------------------------|--------------------------------------|

|   |                          |  |  |
|---|--------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>1-16-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u> |
|---|--------------------------|--|--|

|   |   |  |                             |
|---|---|--|-----------------------------|
| DATE REC'D BY LOCAL REG. <u>Jan 15 1949</u> | REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Barber Funeral Service</u> | ADDRESS <u>Columbia, Mo</u> |
|---|---|--|-----------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

RECEIVED  
District Health Officer No. 9,  
District File Number  
JAN 21 1949  
Date Filed

JAN 25 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed M. S. Whitfield

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3893

P. O. Address Columbia md

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.