No. 300
10.48

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

FILED MAR 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9030

State File No. 180

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 179

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Vernon
c. LENGTH OF STAY (in this place): 237 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Missouri State Sanatorium

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Douglas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ava
d. STREET ADDRESS (If rural, give location): 1

3. NAME OF DECEASED (Type or Print)
a. (First): Orville
b. (Middle):
c. (Last): Brown

4. DATE OF DEATH (Month) (Day) (Year): Mar 12, 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 4, 1910
9. AGE (In years last birthday): 38 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furniture dealer
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Ava, Missouri
12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: James L. Brown
13b. MOTHER'S MAIDEN NAME: Mellvina Morris
14. NAME OF HUSBAND OR WIFE: Kiree Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME: E. McMichael, Record Clerk, Mo. State San — **ADDRESS**: Mt. Vernon, Mo.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Tuberculous meningitis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pulmonary Tuberculosis — Abt. 1 yr.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 19, *19* 48, *to* Mar 12, *19* 49, *that I last saw the deceased alive on* Mar 12, *19* 49, *and that death occurred at* 8:25 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. A. Brasher M.D.
23b. ADDRESS: Mount Vernon, Missouri
23c. DATE SIGNED: 3-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3-12-49
24c. NAME OF CEMETERY OR CREMATORY: Ava Cemetery
24d. LOCATION (City, town, or county) (State): Ava Mo

DATE REC'D BY LOCAL REG.: 3-16, 1949
REGISTRAR'S SIGNATURE: Cecil Hendricks M.D. 411
25. FUNERAL DIRECTOR'S SIGNATURE: Max L. Fossett — **ADDRESS**: Mt Vernon Mo

(Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

BIRTH NO. ..... REG. DIST. NO. ..... PRIMARY REG. DIST. NO. ..... Registrar's No. .....

RECEIVED
Registrar's Office No. 0;
District Health Officer No. 0;
District File Number 3 49 302
Date Filed 2-17-49

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased ... residence before admission)
a. STATE
b. COUNTY
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
d. STREET ADDRESS (If not in hospital or institution, give street address or location)

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last)
4. DATE OF DEATH (Month) (Day) (Year)

5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)
ANTECEDENT CAUSES
Morbid conditions, if any, giving the underlying cause last.
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 working under my personal supervision.

Student Embalmer No. .....

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WORK ☐ AT WORK ☐
21f. HOW DID INJURY OCCUR?

Signed Max L. Tousel

Licensed Embalmer No. 4252

P. O. Address Mt Vernon Mo

Signed ..... Student Embalmer

22. I hereby certify that I have seen the deceased from ..... 19 ..... to ..... 19 ..... and that death occurred at ..... m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

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.

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

MISSOURI—USUAL DIVISION OF HEALTH—NOT A PERMANENT RECORD