

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29297

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>986</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Buchanan</u>				a. STATE <u>Missouri</u>		b. COUNTY <u>Buch.</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>4 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2214 North 7th Street</u>				d. STREET ADDRESS (If rural, give location) <u>2214 North 7th Street</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) <u>Etta</u>		b. (Middle) <u>Cooley -</u>		c. (Last) <u>Brown</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 7, 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 5, 1877</u>	
9. AGE (In years last birthday) <u>72</u>		10. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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 <u>William Cooley</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Walker</u>		14. NAME OF HUSBAND OR WIFE <u>James H. Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Earl Brown - St. Joseph, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		ANTECEDENT CAUSES DUE TO (b) <u>Arterio-sclerotic cardiovascular disease</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Senility; Emasculation</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug 15, 1949</u> , to <u>Sept 7, 1949</u> , that I last saw the deceased alive on <u>Sept 5, 1949</u> , and that death occurred at <u>6:15 am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Deceased or title) <u>Dr. Grant M.D.</u>				23b. ADDRESS <u>St. Joseph, Mo</u>		23c. DATE SIGNED <u>9.8.49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 9, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 14, 1949</u>		REGISTRAR'S SIGNATURE <u>G. C. Jenkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stamey Funeral Home - St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement (on Reverse Side))

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

NOV 1904

**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.

Student .....  
Student Embalmer

Signed *Charles M. Gorman*

Licensed Embalmer No. *4487*

P. O. Address *St. Joseph*

**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.