

FILED JUL 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24029**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **240**

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal 0644	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fevering Hospital		d. STREET ADDRESS (If rural, give location) 920 North St	

3. NAME OF DECEASED (Type or Print) a. (First) Jennie b. (Middle) Brown c. (Last) Brown			4. DATE OF DEATH (Month) (Day) (Year) 6 20 - 50		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 6-25-1886	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New London Mo	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Henry Monroe	13b. MOTHER'S MAIDEN NAME Sarah Smith	14. NAME OF HUSBAND OR WIFE John Brown
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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 Frankie Brown 920 North St Hannibal, Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Impacted, Inflammatory		INTERVAL BETWEEN ONSET AND DEATH 4 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertensive cardio vascular disease		
	DUE TO (c) stroke		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			6 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:00** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS 1001 Redway	23c. DATE SIGNED 7/14/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-24-1950	24c. NAME OF CEMETERY OR CREMATORY Robinson	24d. LOCATION (City, town, or county) (State) Hannibal Mo
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DATE REC'D BY LOCAL REG. 7-14-50	REGISTRAR'S SIGNATURE E. M. Lucke	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Geo E Roberts Hannibal, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6/24/50

RECEIVED JUL 20 1950
MARION CO. HEALTH DEPT.
DATE FILED JUL 22 1950

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

W. G. Roberts

Licensed Embalmer No. 2113

P. O. Address Hammibal 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.