No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38315

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9361

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 30 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1321a South Broadway

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2239
d. STREET ADDRESS (If rural, give location): 1321a South Broadway

3. NAME OF DECEASED (Type or Print)
a. (First): NANCY
b. (Middle): C
c. (Last): BROWN

4. DATE OF DEATH (Month) (Day) (Year): November 1, 1950

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: Mar. 1, 1866
9. AGE (In years last birthday): 84 — 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): House-wife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Perry County, Illinois
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: William Anderson
13b. MOTHER'S MAIDEN NAME: Gibson
14. NAME OF HUSBAND OR WIFE: C.G. Brown

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: Grover C. Brown 1321 So. Broadway

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) Cancer of the Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating 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. Chronic Myocarditis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none
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? 156 A

22. *I hereby certify that I attended the deceased from* Sept 10, 1950, *to* 11/1, 1950, *that I last saw the deceased alive on* 11/1, 1950, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: 2105 So Broadway
23c. DATE SIGNED: 11/3/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-4-50
24c. NAME OF CEMETERY OR CREMATORY: Tower Grove
24d. LOCATION (City, town, or county) (State): Murphysboro, Illinois

DATE REC'D BY LOCAL REG.: NOV 3 1950
REGISTRAR'S SIGNATURE: J B [signature]
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: McLAUGHLIN FUNERAL HOME, INC. 2301 Lafayette Avenue

(Licensed Embalmer's Statement on Reverse Side)

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.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 33 [illegible]

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.