

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29161

State File No. _____

FILED SEP 15 1953

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 126

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lebanon</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lebanon</u>	
c. LENGTH OF STAY (In this place) <u>2 Days</u>		d. STREET ADDRESS (If rural, give location) <u>Buffalo Road</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wallace Memo. Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>C.</u> c. (Last) <u>Brown</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 1 1953</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Sept. 8 1866</u>		9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Glasgow Ky.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Belfield Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Sullivan</u>		14. NAME OF HUSBAND OR WIFE <u>Mattie Brown</u>	
--	--	---	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Abe Brown</u> ADDRESS <u>Lebanon Mo.</u>	
--	--	-------------------------------	--	---	--

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic ht. dis. 20 yrs.</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Skin cancer on nose</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 Aug. 10, 1953 to 9-1-1953, that I last saw the deceased alive on 9-1-1953 and that death occurred at 4:45 pm, from the causes and on the date stated above.

23a. SIGNATURE <u>B. B. Hines, M.D.</u> (Degree or title)		23b. ADDRESS <u>Lebanon, Mo.</u>		23c. DATE SIGNED <u>9-3-53</u>	
---	--	----------------------------------	--	--------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/2/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>McBride</u>	
				24d. LOCATION (City, town, or county) (State) <u>Laclede Co. Mo.</u>	

DATE REC'D BY LOCAL REG. <u>9-5-1953</u>		REGISTRAR'S SIGNATURE <u>Hella L. Day</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer</u> ADDRESS <u>Lebanon Mo</u>	
--	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

532
10-48

SEP 12 1953 132

Received _____
Laclede County Health Unit
File No. 9-53-132
Date Filed SEP 14 1953

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 J. R. Palmer

Licensed Embalmer No. 2268

P. O. Address Channon 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.