

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23589

BIRTH NO.		REG. DIST. NO. <u>184</u>		PRIMARY REG. DIST. NO. <u>2038</u>		Registrar's No. <u>405</u>	
1. PLACE OF DEATH a. COUNTY <u>LINN</u> b. CITY (If outside corporate limits, write RURAL and give town or township) <u>BROOKFIELD</u> c. LENGTH OF STAY (in this place) <u>2 WKS</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>LINN</u> c. CITY OR TOWN <u>LINNEUS</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> STREET ADDRESS (If rural, give location) <u>0J-80</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARCUS</u> b. (Middle) <u>LAFAYETTE</u> c. (Last) <u>BROWN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-14-54</u>		5. SEX <u>MALE</u>		
6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>8-11-82</u>		9. AGE (In years last birthday) <u>71</u> 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) <u>Farm Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Jackson Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Dorinda Hickenbottom</u>		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) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>OPAL FRAZER, LINNEUS, MO.</u> ADDRESS _____			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolism - thrombotic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>2nd + 3rd degree burns feet legs + thighs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>14 days</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) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>about home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Linneus Linn Mo</u>		21f. HOW DID INJURY OCCUR? <u>Prolonged exposure to sun while in car.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6-30-54 1P.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>6-30-54</u> to <u>7-14-54</u> , that I last saw the deceased alive on <u>7-13-54</u> , 19 <u>54</u> , and that death occurred at <u>6:25 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>John R. Owen M.D.</u>			23b. ADDRESS <u>Brookfield Mo</u>			23c. DATE SIGNED <u>7-14-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>7-16-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LACLEDE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>LACLEDE, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>7-15-54</u>		REGISTRAR'S SIGNATURE <u>Nadine Lambach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Beathers, Linneus, Missouri</u> ADDRESS _____			

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

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.....
Signature of Student Embalmer

Signed..... *WR Wright*

Licensed Embalmer No. *4653*

P. O. Address *Leeds, M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.