

FILED NOV 23 1955

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH35815  
State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>346</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (In this place township) <u>8 dys</u>		c. CITY OR TOWN <u>Macon</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Laughlin Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>418 North Ruby</u> <u>2611</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jeanette</u>		b. (Middle) <u>Maureen</u>		c. (Last) <u>Brown</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 19, 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1955</u>	
9. AGE (In years last birthday) <u>8</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u>8</u> Min.		11. BIRTHPLACE (City and State or Foreign Country) <u>Kirksville, Mo.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William W. Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Fern Allen</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>7625</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William W. Brown, Macon, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary atelectasis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>9 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)		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>Nov 12, 1955</u> to <u>Nov. 19, 1955</u> , that I last saw the deceased alive on <u>Nov 19, 1955</u> , and that death occurred at <u>11:42 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Philadred Luback M.D.</u> (Degree or title)				23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>11-21-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 20, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Salem</u>		24d. LOCATION (City, town, or county) (State) <u>Excello, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>11-22-55</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Lambert</u>		ADDRESS <u>Macon, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Howard F. Myers*.....

Licensed Embalmer No. *44*.....

P. O. Address *Macon*.....

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.