

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010582
STATE FILE NUMBER

FILED APR 7 1958
Registration District No. 178 Primary Registration District No. 4283 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY LEWIS		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE EWING, MO. COUNTY Lewis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ewing		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN EWING. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First David Middle FRANKLIN Last Brown			4. DATE OF DEATH Month Mar. Day 25 Year 1958		
--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22 1888	9. AGE (In years last birthday) 70	10. FUNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	----------------------------------	---	--	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	---

13a. FATHER'S NAME David Brown	13b. MOTHER'S MAIDEN NAME Claudie Fee	14. NAME OF HUSBAND OR WIFE X
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes World War I	16. SOCIAL SECURITY NO. X	17. INFORMANT John Brown, Ewing, Mo	Address
--	-------------------------------------	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate gland with metastasis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 177X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 0
---	--

20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	---	--	---

21. I attended the deceased from Death occurred at DOA	Aug 1952 , to 25 Mar 1958 and last saw him alive on 20 Mar 1958 m on the date stated above; and to the best of my knowledge, from the causes stated.
--	--

22a. SIGNATURE (Degree or title) John W. Wells, D.O.	22b. ADDRESS New Hope MO	22c. DATE SIGNED 27 Mar 58
--	------------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Mer 27-58 Malone	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Ewing MO	23d. LOCATION (City, town, or county) (State)
--	-----------	---	---

24. FUNERAL DIRECTOR Thomas Ball	ADDRESS Ewing	25. DATE RECD. BY LOCAL REG. 3-31-58	26. REGISTRAR'S SIGNATURE P. W. Jennings, M.D.
--	-------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

300
1-57

APR 9 1958

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 *L. M. Crutell*

Licensed Embalmer No. *4905*
P. O. Address *Cwing 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.