

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000925

STATE FILE NUMBER

FILED VS JAN 22 1960

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>SULLIVAN</u>		Length of stay in 1b OR TOWN <u>21 YRS.</u>	c. CITY OR TOWN <u>SULLIVAN</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>146 OAK ST.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>146 OAK ST.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARGARET T.</u> Middle <u>BROWN</u> Last <u>BROWN</u>	4. DATE OF DEATH Month <u>JAN.</u> Day <u>14</u> Year <u>1960</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 4, 1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>DIVIDE, ILL.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ISAAC GREER</u>	13b. MOTHER'S MAIDEN NAME <u>CATHERINE HAYES</u>	14. NAME OF HUSBAND OR WIFE <u>GEORGE EDGAR BROWN</u>
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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. <u>NONE</u>	17. INFORMANT <u>ORPHA HERRON, SULLIVAN, MO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u></u> STATE <u></u>
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21. I attended the deceased from <u>1954</u> to <u>Jan 1960</u> and last saw her/him alive on <u>Dec 19 - 59</u> Death occurred at <u>4:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert M. [Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Sullivan, Missouri</u>	22c. DATE SIGNED <u>Jan 16, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 16, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CAVE SPRING BAPTIST CH. CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>SULLIVAN RR 2 MO.</u>
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24. FUNERAL DIRECTOR <u>H. M. EATON, SULLIVAN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>1-16-60</u>	26. REGISTRAR'S SIGNATURE <u>Thomas A. Humphrey</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harrison W. Eaton

Licensed Embalmer No. 5068

P. O. Address Bullwinn,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con-
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.