

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045447

STATE FILE NUMBER

AMENDED

Registration District No. 178 Primary Registration District No. \_\_\_\_\_ Registrar's No. 103

FILED JAN 4 1962

1. PLACE OF DEATH a. COUNTY <b>LEWIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>LEWIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LEWISTOWN</b>		Length of stay in 1b <b>3 YEARS</b>	c. CITY OR TOWN <b>LEWISTOWN</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>XXXXXXXXXXXXXXXXXX</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>XXXXXXXXXXXXXXXXXX</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>PHILLIP</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>27</b> , Year <b>1961</b>	
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/72</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>	11. BIRTHPLACE (City and state or country) <b>GILIAD, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>WILLIAM BROWN</b>	13b. MOTHER'S MAIDEN NAME <b>BELLE ADAMS</b>	14. NAME OF HUSBAND OR WIFE <b>LEONA BROWN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year and date of service) <b>NO</b> <b>XXXXXXXXXX</b>	17. INFORMANT <b>ALLEN BROWN, LEWISTOWN, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma Prostate</b>		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 _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>LEWISTOWN</b>	COUNTY <b>LEWIS</b>	STATE <b>MISSOURI</b>
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21. I attended the deceased from June 1954 to 27 Dec 61 and last saw <sup>them</sup>him alive on 27 Dec 61  
Death occurred at 12:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John W. Smith D.O.</b>	22b. ADDRESS <b>Lewistown Mo</b>	22c. DATE SIGNED <b>28 Dec 61</b>
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23b. DATE <b>12/29/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LEWISTOWN CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>LEWISTOWN, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>Charles L. ...</b>	ADDRESS <b>LEWISTOWN, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-30-'61</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Nancy Lloyd</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Charles L. Arnold, Jr.*

Licensed Embalmer No. 4667

P. O. Address LEWISTOWN, MISSO

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.