

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-007322  
STATE FILE NUMBER

AMENDED

Registration District No. 201 Primary Registration District No. \_\_\_\_\_ Registrar's No. 56

FILED FEB 19 1962

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Nodaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Polk Twp.</b>		Length of stay in 1b <b>4 years</b>	c. CITY OR TOWN <b>Maryville</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <b>May</b> Middle <b>----</b> Last <b>Browne</b>	4. DATE OF DEATH Month <b>Feb.</b> Day <b>5,</b> Year <b>1962</b>
---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1855</b>	9. AGE (last birthday) <b>106</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	--------------------------------------	--------------------------------------	--	--

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

13a. FATHER'S NAME <b>William V. Browne</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Lee</b>	14. NAME OF HUSBAND OR WIFE <b>---</b>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs Howard Wray, Maryville, Mo.</b>	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) <b>Bronchial Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>
DUE TO (b) <b>following influenza</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)	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
---	--

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.)
--	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
---

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 _____ STATE _____
--	--	--

21. I attended the deceased from 2-1-50 to 2-5-62 and last saw her <sup>him</sup> alive on 2-5-62  
Death occurred at 8:30 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>E. P. Jones M.D.</b>	22b. ADDRESS <b>Maryville, Mo.</b>	22c. DATE SIGNED <b>2-7-62</b>
---	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-7-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins,</b>	23d. LOCATION (City, town, or county) (State) <b>Hopkins, Mo.</b>
--	----------------------------	---	--

24. FUNERAL DIRECTOR <b>Stanley S. Johnson</b>	ADDRESS <b>Hopkins, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-10-62</b>	26. REGISTRAR'S SIGNATURE <b>Beas Holt</b>
---	--------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

**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  \_\_\_\_\_

Licensed Embalmer No. 3963

P. O. Address Hopkins, Mo.

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.