

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037288

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District 30720 Registrar's No. 194
 FILED OCT 7 1962

VS 300
Rev. 4/59

6975
20970

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u> | | Length of stay in 1b <u>7 months</u> | c. CITY OR TOWN <u>Malta Bend</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Streets not numbered</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE LANGHORNE BROWN</u> | | 4. DATE OF DEATH Month Day Year <u>September 26, 1962</u> | |
| 5. SEX <u>Male</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>4-24-1890</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Doctor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u> | 9. AGE (last birthday) <u>72</u> |
| 11. BIRTHPLACE (City and state or country) <u>Malta Bend, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>James R. Brown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Nina Frances Meier</u> | 14. NAME OF HUSBAND OR WIFE <u>Lulu B. Brown dec.</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u> | | 17. INFORMANT Address <u>Richard M. Brown, Topeka, Kansas</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 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.) | |
| 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 <u>Feb 62</u> , to <u>9-25-62</u> and last saw him alive on <u>9-25-62</u> Death occurred at <u>4 am.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>R. F. Fisher M.D.</u> | | 22b. ADDRESS <u>Marshall, Mo.</u> | 22c. DATE SIGNED <u>9-26-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9-28-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Slater City Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Campbell-Lewis</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-26-62</u> | 26. REGISTRAR'S SIGNATURE <u>Cecil G. Read</u> |

OCT 2 1962

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

R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall 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.