WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STALEY & LANDIS.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pettis

Township Lake Creek or Village or City (No. St.; Ward)

Registration District No. 669

Primary Registration District No. 5897

File No. 2033

Registered No. 8

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Josephine Lenore Brown

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Feb (Month) 8 (Day), 1914 (Year)

AGE yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Sedalia

PARENTS

NAME OF FATHER J H Brown

BIRTHPLACE OF FATHER (City or town, State or foreign country) Sedalia

MAIDEN NAME OF MOTHER Josie Anderson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sedalia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C L Manbury

(Address) Sedalia

Filed Jan 10 1915 S. M. Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. (Month) 26 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 25, 1914, to Dec 26, 1914, that I last saw her alive on Dec 25, 1914, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. mos. 21 ds.

Contributory (Secondary) Broncho pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Chas. [illegible] M. D.

Dec 26, 1914 (Address) Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Flat Creek Bap. Ch.

DATE OF BURIAL 12/28, 1914

UNDERTAKER Staley & Landis

ADDRESS Sedalia

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS.

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... , 191....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER
(City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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