

FILED APR 24 1946

Registration District No. 226

Primary Registration District No. 4337

Registrar's No. 9.

## 1. PLACE OF DEATH:

(a) County Memor  
(b) City or town Madison Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME LITER BROWN

3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married. W  
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 27 1869  
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Madison Mo Rural  
(City, town, or county) (State or foreign country)10. Usual occupation Barber

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Wm J Brown  
13. Birthplace Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Prasa Pet Davis  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm J Brown  
(b) Address 100 So 1st St  
17. (a) Interment (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smith Hill Madison Mo  
18. (a) Signature of funeral director Paul G. Thompson  
(b) Address Madison Mo  
19. (a) 17746 (b) Cline Little  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Memor  
(c) City or town Madison  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3  
year 1946 hour 10am minute 20 M.21. I hereby certify that I attended the deceased from Dec 4 1945 to Jan 3 1946  
that I last saw him alive on Jan 3 1946  
and that death occurred on the date and hour stated above.Immediate cause of death Intestinal Influenza Duration 1 dayDue to \_\_\_\_\_  
Due to \_\_\_\_\_Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy 336

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of Injury \_\_\_\_\_

23. Signature W R Turner (M. D. or other) DO  
Address Madison Mo Date signed 1-4-46

RECEIVED

District Embalmer, Officer No. 10

District No. 4-46-887

Date filed APR 22 1946

### 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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Frederic A. Thompson*

Licensed Embalmer No. 1470

P. O. Address. *Madison, 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 this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 226

Primary Registration District No. 4837

Registrar's No. ....

1. PLACE OF DEATH:

- (a) County monroe  
(b) City or town madison  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. (Specify whether

In this community  
years, months or days)

3. (a) PRINT  
FULL NAME

Liter Brown

3. (b) If veteran,  
name war.

3. (c) Social Security  
No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married,  
divorced wid

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if  
alive. years

7. Birth date of deceased aug 27  
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 1 Unless than one day  
hr. min.

9. Birthplace ms  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant  
(b) Address  
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation  
13. (a) Signature of funeral director

- (b) Address  
19. (a) 11/7/46 (b) (Clive Little)  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County monroe  
(c) City or town madison  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug year 1946 hour 11 minute 46 M.

21. I hereby certify that I attended the deceased from 1946 to 1946,  
that I last saw him alive on 11/7/46 and that death occurred on the date and hour stated above.  
Immediate cause of death. Duration

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)  
Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

13923