

FILED APR 13 1947

Registration District No. _____

Primary Registration District No. **6178**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
 (b) City or town _____
(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

George H. Brown

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M Color or race D

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan - 12 - 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 3

If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county)

Kentucky
(State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name unknown 9

13. Birthplace _____
(City, town, or county)

9
(State or foreign country)

14. Maiden name Mary Calcutt

15. Birthplace unknown
(City, town, or county)

9
(State or foreign country)

16. (a) Informant Mrs Zofsch

(b) Address Excelsior 700

17. (a) Burns (b) Date thereof 3-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Family Church

(e) Signature of funeral director Dunkley

(b) Address _____

19. (a) 4-10-47 (b) Walter Rennie
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shannon
 (c) City or town Excelsior
(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 Mar day 14
 year 1947 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on Mar - 10 -, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
 Due to _____
 Due to _____
 Other conditions 93 P
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN

 Underline the cause to which death should be charged statistically.

Major findings:
 Of operations _____
 Of autopsy _____

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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Frank R. Rode (M. D. or other) _____
 Address Excelsior Date signed 3-14-47

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.