

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

Do not use this space.

2125

1. PLACE OF DEATH  
 County Ray Co Registration District No. 743  
 Township Orrick Primary Registration District No. 4445  
 City Orrick (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2. FULL NAME Frances Ann Brown  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Arthur J. Brown Deceased

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/26/1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
82 1 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) about Jan 1, 1930 11. Total time (years) all spent in this occupation her life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co Mo. 1

FATHER 13. NAME John Conyers  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky 2

MOTHER 15. MAIDEN NAME Ellen Barnister  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT Frank Brown  
 (ADDRESS) Orrick Mo

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Rowland Cem DATE Jan 23<sup>rd</sup>, 1932

19. UNDERTAKER C. V. Gibson  
 (ADDRESS) Orrick Mo

20. FILED Jan 25, 1932 L. E. Ellis Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 24, 1932

22. I HEREBY CERTIFY That I attended deceased from Jan 14, 1932 to Jan 24, 1932  
 Last saw her alive on Jan 24, 1932 Death is said to have occurred on the date stated above, at 3:35 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Impacted fracture of right hip. Date of onset Jan 14, 1932

Other contributory causes of importance:  
Disturbance

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chem Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Accident Date of injury Jan 14, 1932  
 Where did injury occur? in the home at Orrick Mo (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall from stairs  
 Nature of injury fracture of right hip

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) L. E. Ellis M. D.  
 (Address) Orrick Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 25 1932



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Ray  
Township Wrench  
City Wrench (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

Registration District No. 743  
Primary Registration District No. 4445

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jun 24, 1932

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Date of onset \_\_\_\_\_

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Impacted fracture of right hip

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Fell out of a chair

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

Name of operation 1860 Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

20. FILED

Mar 5, 1932 L. E. Ellis Registrar

(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH IN plain terms, so that it may be properly recorded. Exact statement of OCCUPATION is very important.

new information should be carefully supplied. A-C-B should be stated EXACTLY. PHYSICIAN should state

S-21/a.5