

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34422**

BIRTH NO. _____ REG. DIST. NO. **297** PRIMARY REG. DIST. NO. **6022** Registrar's No. **64**

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Layfayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (Rural) Richmond		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN Lexington
d. FULL NAME OF HOSPITAL OR INSTITUTION Highway 10-2 1/2 mi. N. Richmond		STREET ADDRESS (If rural, give location) 1843 Poplar St.	
3. NAME OF DECEASED (Type or Print) a. (first) WALTER R b. (Middle) WILLIAM c. (Last) BROWN		4. DATE OF DEATH (Month) (Day) (Year) October 15 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 1, 1923
9. AGE (In years last birthday) 32		IF UNDER 1 YEAR Months 4 Days 14	IF UNDER 12 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and State or Foreign Country) Lexington, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME George W. Brown	
13b. MOTHER'S MAIDEN NAME Minnie Duncan		14. NAME OF HUSBAND OR WIFE Mary Catherine Shroyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War 2		16. SOCIAL SECURITY NO. 495-20-9346	
17. INFORMANT'S SIGNATURE OR NAME Mr. George W. Brown		ADDRESS Lexington, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neck Broken ANTECEDENT CAUSES DUE TO (b) Automobile Wreck. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) car accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	
21c. (CITY, TOWN, OR TOWNSHIP) Richmond (COUNTY) Ray (STATE) Mo.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10-15-55 2A		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? automobile struck bridge abutment			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
22a. SIGNATURE (Degree or title) Dr. J. F. Robey		23b. ADDRESS Richmond Mo	
23c. DATE SIGNED 10-15-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-18-55	
24c. NAME OF CEMETERY OR CREMATORY Maryplech Cem.		24d. LOCATION (City, town, or county) (State) Lexington Mo	
DATE REC'D BY LOCAL REG. Oct 19-1955		REGISTRAR'S SIGNATURE Malcolm Jackson 273	
25. FUNERAL DIRECTOR'S SIGNATURE Harold L. Walker		ADDRESS Lexington, Mo	

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

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MAY 5 1956

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MAY 5 1956

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 *Harold P. Walker*

Licensed Embalmer No. *45*
P. O. Address *Lexington,*

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.