

PLACE OF DEATH

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

County \_\_\_\_\_

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City St. Louis

Registration District No. 791

File No. 8718

Primary Registration District No. 1003

Registered No. 2039

(NO. 4243 Desoto av St. 71 Ward)

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

FULL NAME Donald A. Brown

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH Feb 4, 1910  
(Month) (Day) (Year)

AGE 5 yrs. 90 mos. 20 ds. If LESS than 1 day, \_\_\_ hrs. \_\_\_ min.?

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

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

PARENTS	NAME OF FATHER <u>Frank Brown</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>
	MAIDEN NAME OF MOTHER <u>Flora Maupin</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James F. Randall  
(ADDRESS) 4243 Desoto av

Filed FEB 24 1911 W. Wheeler Board  
191 \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 23, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 22, 1911, to Feb 23, 1911, that I last saw him alive on Feb 23, 1911, and that death occurred, on the date stated above, at 9:20 pm. The CAUSE OF DEATH\* was as follows:

Shock from  
Asphyxiation from sleep  
Patent  
1570 (Duration) yrs. mos. ds.  
Contributory \_\_\_\_\_  
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. R. Blair M.D. Geo. W. Longley M.D.  
Feb 24, 1911 (Address) Metrol City

\*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 Owensville Mo

PLACE OF BURIAL OR REMOVAL <u>Owensville Mo</u>	DATE OF BURIAL <u>2 24, 1911</u>
UNDERTAKER <u>Edw. F. Howard &amp; Son</u>	ADDRESS <u>3349 Market St</u>

Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important.

