

MAY 13 1935

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

ISOLATION HOSPITAL

Do not use this space.

14810

1. PLACE OF DEATH

County.....

Registration District No. **1003**File No. **3661**

Township.....

Primary Registration District No.

Registered No.

City *St Louis Mo* (No.)

St. Ward)

2. FULL NAME

Robert Brown(a) Residence, No. *3021 Magnolia St.* *17* Ward.

(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

3. SEX

Male

4. COLOR OR RACE

W. White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

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

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

July 1-1929

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*5**9**19*

OCCUPATION

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

at home

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)

11. Total time (years) spent in this occupation

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

St Louis Mo

13. NAME

Robert Brown

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

St Louis Mo

15. MAIDEN NAME

Lorraine Schmeiser

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

St Louis Mo

17. INFORMANT (ADDRESS)

*Stella Brady
5600 Archway*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *St Pauls churchyard* DATE *Apr 23 1935*

19. UNDERTAKER (ADDRESS)

*Wachey Galden
2331 Broadway*

20. FILED

*APR 23 1935**J. Brubaker*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 20, 1935*22. I HEREBY CERTIFY, that I attended deceased from *April 18, 1935*, to *April 20, 1935*I last saw him alive on *April 28, 1935* Death is saidto have occurred on the date stated above, at *8 A.* m.

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

*Scarlet Fever*Date of onset
*4-13**Toxemia*

Other contributory causes of importance:

*Meningismus*Name of operation *None* Date of *No*What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *No* Date of injury....., 19.....Where did injury occur? *No* (Specify city or town, county, and State)

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

Manner of injury.....

Nature of injury.....

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

If so, specify.....

(Signed) *John Schenck* M. D.(Address) *ISOLATION HOSPITAL*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

