

OCT 1 1939

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

31239
Do not use this space.

791
1003

Registered No. 8302

1. PLACE OF DEATH
 (a) County Registration District No.
 (b) Township Primary Registration District No.
 (c) City St. Louis (d) Street No. Homer G. Phillips Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *630 Infant* Brown
 (a) Residence, No. 2239 Spruce St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-10-39

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

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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) St. Louis, Mo. (STATE OR COUNTRY)

FATHER
 13. NAME Perry Brown
 14. BIRTHPLACE (CITY OR TOWN) Stewart, Miss. (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME Josie Whitfield
 16. BIRTHPLACE (CITY OR TOWN) Columbus, Miss. (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) *Ether May Shepard*
 2601 N. Whittier St.

18. BURIAL, CREMATION, OR REMOVAL PLACE CITY CEMETERY DATE 9-28-39

19. FUNERAL DIRECTOR (NAME) *Ara Hamilton*
 (ADDRESS) City Health Dept.

20. FILED SEP 27 1939 *J. B. ...*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-10-39

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 4:43PM

The principal cause of death and related causes of importance were as follows:
 Unknown (Stillborn)

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 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?..... Date of injury....., 19____
 Where did injury occur?..... (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) *J. B. ...* M. D.
 (Address) 2601 N. Whittier

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X 16603

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, above space should be left blank.