E8769

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 8-17-39 I X19511

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

791

State File No. 34560

Registration District No. 1003 Primary Registration District No. Registrar's No. 9098

1. PLACE OF DEATH: NOV 13 1939

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Premature (Specify whether years, months or days)

In this community xPremature (8 min.)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County x

(c) City or town St. Louis, 26
(If outside city or town limits, write "RURAL")

(d) Street No. 1408 Clinton
(If rural, give location)

(e) If foreign born, how long in U. S. A.? x years.

3. (a) PRINT FULL NAME Brooks, Baby 620

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced x

6. (b) Name of husband or wife x

6. (c) Age of husband or wife if alive x years

7. Birth date of deceased September 19, 1939 (Month) (Day) (Year)

8. AGE: Years Premature | Months 0 | Days 0 | If less than one day hr. 8 min.

9. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation x 0

11. Industry or business x 1

FATHER
12. Name Jesse Brooks
13. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Edna Downs
15. Birthplace (City, town, or county) Maine (State or foreign country)

16. (a) Informant's own signature Ann Morrison

(b) Address City Hospital, #1

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-26-39 (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director David Van Forsten

(b) Address City Hosp #1

19. (a) OCT 25 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 19, year 1939 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from September 19, 1939 to September 19, 1939 that I last saw her alive on September 19, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death PREMATURE

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

159

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature John F. Flynn (M. D. or other)

Address 1515 Lafayette, Date signed 10/1/39

(Licensed Embalmer's Statement on Reverse Side)

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.