

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41713

JAN 12 1940

Registrar's No. 10836

Registration District No. 101

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1005
St. Louis
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
Unknown (Specify whether
In this community.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 23
(If outside city or town limits, write "RURAL")
1427 a So Third
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1939 hour 1:00 minute 35 P. M.

21. I hereby certify that I attended the deceased from
December 5, 1939, to December 17, 1939
that I last saw her alive on December 17, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of left Breast c Metastasis
to Spine & Lungs About 1 year
Duration

Due to _____
Due to _____
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

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) _____
(e) Means of injury _____
While at work _____
23. Signature R. Chackey (M. D. or other)
Address 2601 N Whittier Date signed _____

3. (a) PRINT FULL NAME

Eliza Brown 6.50

3. (b) If veteran, name war

No.

3. (c) Social Security No.

No. No

4. Sex

Female

5. Color of race

Col.

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

Married

6. (b) Name of husband or wife

William Brown

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

37 years

7. Birth date of deceased

March

1, 1906

(Month) (Day) (Year)

8. AGE:

Years

33

Months

9

Days

16

If less than one day

hr. _____ min.

9. Birthplace

Cofferville

Mississippi

(City, town, or county)

(State or foreign country)

10. Usual occupation

housewife

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Mississippi

(City, town, or county)

(State or foreign country)

14. Maiden name

Genevieve

15. Birthplace

Mississippi

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

William Brown

(b) Address

1427 a So. Third St.

17. (a) Burial

(b) Date thereof 12-21-39

(Burial, cremation, or removal)

Father Dickson

(c) Place: burial or cremation

18. (a) Signature of funeral director

Mary Wade

(b) Address

4202 Chittenden Ave.

19. (a) DEC 19 1939

(b) J. F. Baskin

(Date received local registrar)

(Registrar's signature)

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.

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

....., Registered Apprentice No.....

Licensed Embalmer No. *2698*

P. O. Address. *2769 Chouteau*

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.