

E16928

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 9217
Registrar's No. 2700Registration District No. 791Primary Registration District No. 1003

1. PLACE OF DEATH:

(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 13 Days
 In this community about 40 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Brike3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex Female5. Color or
race white6. (a) Single, widowed, married,
divorced WIDOW6. (b) Name of husband or wife
Rohi Brike6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased March 23 1887
(Month) (Day) (Year)8. AGE: Years 82 Months 11 Days 27
If less than one day hr. _____ min. _____9. Birthplace England
(City, town, or county) (State or foreign country)10. Usual occupation At Home

11. Industry or business

12. Name John Williams13. Birthplace England
(City, town, or county) (State or foreign country)14. Maiden name UNKNOWN15. Birthplace unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature A. Miller(b) Address 4355 Washington17. (a) Valhalla (b) Date thereof March 23
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Burial18. (a) Signature of funeral director Chas A Bree(b) Address 445 Washington19. (a) MAR 22 1940 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 22
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1024 Morrison
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20,
year 1940 hour 6:00 minute _____ P. M.21. I hereby certify that I attended the deceased from March
7, 1940, to March 20, 1940,
that I last saw her alive on March 20, 1940,
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral thrombosis Duration 2 1/2
yearsDue to Generalized arteriosclerosis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 9 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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?
While at work? _____ (Specify type of place) (e) Means of injury _____23. Signature Walter Ford (M. D. or other) _____
Address 1515 Lafayette Date 3/21/40

(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.....

Howard F. Rowland.

Licensed Embalmer No.....

3114

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.