

4455
S. No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23759
State File No. 6204

FILED AUG 25 1940 91

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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 10 Days (Specify whether
In this community Life
years, months or days)

8. (a) PRINT FULL NAME Baby Brown 1.50

3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Newborn 6. (c) Age of husband or wife if alive Newborn years

7. Birth date of deceased July 4, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name Barter Brown
18. Birthplace Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Bertha Glass
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Morrison
(b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 7 25 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. D. Hawker
(b) Address City Hospital, No. 1

19. (a) JUL 24 1940 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limit, write "RURAL")
(d) Street No. 1743 Missouri Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14,
year 1940 hour 6:00 minute A. M.

21. I hereby certify that I attended the deceased from July
4, 1940, to July 14, 1940
that I last saw him alive on July 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Patent Foramen Ovale
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Patent Foramen Ovale

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)
(c) Means of injury _____

23. Signature W. D. Hawker (M., D., or other)
Address 1515 Lafayette Date signed 7/25/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.