

No. 2
-11-10-39
5-17-40
I X

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40201**

Registrar's No. **9972**

JAN 15 1940 791

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Josephine Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether
In this community 8 days
years, months or days)

3. (a) PRINT FULL NAME Charles Joseph Brady

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 21 1940
(Month) (Day) (Year)

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

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Charles Joseph Brady
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Margaret M. DeRuse
15. Birthplace Pere DeRuse Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Charles J. Brady

(b) Address 4119a Redbud

17. (a) Burial (b) Date thereof 11-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Cullen Kelly

(b) Address 1414 N. Taylor Ave

19. (a) DEC 5 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 10
(If outside city or town limits write "RURAL")
(d) Street No. 4119a Redbud
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 29 day Nov
year 1940 hour 3:15 minute P M.

21. I hereby certify that I attended the deceased from Nov. 21
1940 to Nov. 29 1940
that I last saw him alive on Nov. 29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Premature Birth

Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death)
157

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place)
Means of injury 1 MD

23. Signature E. M. Adams (M. D. or other) MD
Address 3012 Lafayette Date signed 11-29-40

9972

9972

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.