

No. 2  
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-17-39  
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FILED MAY 9 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15890  
Registrar's No. 768

Registration District No. 254 Primary Registration District No. 200

1. PLACE OF DEATH: ST. LOUIS  
(a) County: Koed  
(b) City or town: Koed  
(c) Name of hospital or institution: ROBERT KOED HOSP. 0  
(d) Length of stay: In hospital or institution: 7 yrs - 18 days  
In this community: years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State: MISSOURI (b) County: - 17  
(c) City or town: ST. LOUIS 9  
(d) Street No.: MASONIC HOME - 5351 DELMAR  
(e) If foreign born, how long in U. S. A.: 1 LIFE years

3. (a) PRINT FULL NAME: MILDRED BROOKS  
(b) If veteran, name war: NO  
(c) Social Security No.: NONE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month APRIL day 7  
year 41 hour 11 minute 20 P.M.

4. Sex: FEMALE  
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: 14 years (Day) 1919 (Year)

21. I hereby certify that I attended the deceased from MAR. 23, 1934 to APR. 7, 1941, that I last saw her alive on APR. 7, 1941, and that death occurred on the date and hour stated above.

8. AGE: Years 21 Months 8 Days 23 If less than one day hr. min.

Immediate cause of death: Pulmonary Tuberculosis  
Duration: 12 yrs?

9. Birthplace: HORNERSVILLE MO. (City, town, or county) (State or foreign country)

Due to: [Signature]

10. Usual occupation: -  
11. Industry or business: -

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

MOTHER FATHER  
12. Name: WILLIS BROOKS  
13. Birthplace: HORNERSVILLE MO. (City, town, or county) (State or foreign country)  
14. Maiden name: NAOMI KRAPE  
15. Birthplace: HORNERSVILLE MO. (City, town, or county) (State or foreign country)

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

16. (a) Informant: PATIENT  
(b) Address: Koed Hospital  
17. (a) removal (b) Date thereof: 4/8/41  
(c) Place: burial or cremation: Kenneth Mo.

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?

18. (a) Signature of funeral director: Alexander & Sons  
(b) Address: 6175 Delmar Blvd.  
19. (a) APR 8 1941 (b) H R Meyer M.D. (Registrar's signature)

While at work? [Signature] (Specify type of place) (c) Means of injury: -  
23. Signature: Robert Koechling (M. D. or other) [Signature]  
Address: Robert Koechling, Koed, Mo. Date signed: 4/8/41

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 *Joe McCullon*.....

Licensed Embalmer No. *2460*.....

P. O. Address *6175 Delmar*.....

**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, fact should be so stated above.