

S. No. 2  
I-1-4-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 222210

FILED JUL 6 1942

Registration District No. 154

Primary Registration District No. 200

Registrar's No. 1392

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

**1. PLACE OF DEATH:**  
 (a) County St. Louis  
 (b) City or town Kaol  
 (c) Name of hospital or institution: Robert Kaol Hospital  
 (If outside city or town limits, write "RURAL" and name of township)  
 (d) Length of stay: In hospital or institution 8 mos 12 days  
 (Specify whether years, months or days)  
 In this community 10 years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis 000  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4241 Evans 17  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 1

**3. (a) PRINT FULL NAME** Aaron Brooks  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. 492-01-6438

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month June day 26  
 year 1942 hour 12 minute 30 P M.

4. Sex male 5. Color or race Negro 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: April 30 1912  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan  
October 14, 1941, to June 26, 1942;  
 that I last saw him alive on June 26, 1942;  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years 30 Months 1 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Chronic pulmonary tuberculosis  
 Duration Progressive

9. Birthplace: Little Rock Ark  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 9 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

10. Usual occupation: Shoe factory

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name Will Brooks  
 13. Birthplace England Ark  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Janice Dunlap  
 15. Birthplace Scotts Ark  
 (City, town, or county) (State or foreign country)

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant: Hospital Record  
 (b) Address \_\_\_\_\_

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? \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof 2/1/42  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Little Rock Ark

18. (a) Signature of funeral director: A. F. Walton  
 (b) Address 2707 Standard  
 (Date received local registrar) JUN 29 1942 (c) D. McElroy  
 (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 1  
 23. Signature Frank H. Hinkley (M. D. or other) M.D.  
 Address Robert Kaol Hosp Date signed 6/26/42

Res

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**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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 2649<sup>a</sup> Delmar Blv

**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.**