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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7517

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 327

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Kock
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robt. Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13½ mos. (Specify whether
In this community 6 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4296 Sullivan Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Brooks, Zack

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

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 Feb. 14, 1921 (Month) (Day) (Year)

8. AGE: Years 21 Months 11 Days 22 If less than one day hr. min.

9. Birthplace Shannon, Mississippi (City, town, or county) (State or foreign country)
10. Usual occupation laborer
11. Industry or business

FATHER
12. Name Zack Brooks
13. Birthplace Shannon, Mississippi (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Amie Harvey
15. Birthplace Shannon, Mississippi (City, town, or county) (State or foreign country)

16. (a) Informant patient on entry to hosp.
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof 2-11-43 (Month) (Day) (Year)
(c) Place: burial or cremation OKLONA, MISS
18. (a) Signature of funeral director H. J. Smith
(b) Address 4247 W. Rabadie
19. (a) FEB 9 1943 (Date received local registrar) (b) E. H. McGarvey M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6 year 1943 hour 4 minute 30 A M.

21. I hereby certify that I attended the deceased from Jan. 20, 1942, 19, to Feb. 6, 1943, 19; that I last saw him alive on Feb. 5, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death pulmonary tuberculosis	17 mos.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — 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) no
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. B. Zeis M.D. (M. D. or other)
Address Koch Hospital, Koch Mo Date signed 2/6/43

(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 William C. McDowell, Registered Apprentice No.....,
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

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, fact should be so stated abo