

S. No. 2  
M-9-4-41  
5-17-39  
X29484

15314

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1074

FILED MAY 15 1943

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Koch  
(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 2 yrs 4 mos.  
life (Specify whether 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. 1833 Franklin Ave.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Brown, Herbert  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or Race negro 6. (a) Single, widowed, married, divorced, single  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if alive, \_\_\_\_\_ years  
7. Birth date of deceased 1 23 1912  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
31 3 10 hr. \_\_\_\_\_ min.

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

10. Usual occupation chauffeur

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Wm. Brown  
13. Birthplace Nashville, Tennessee (City, town, or county) (State or foreign country)  
14. Maiden name Lelor Mills  
15. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant pt. on entry to hosp.

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 5-8-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Bernie Love  
(b) Address 3103 Washington

19. (a) 5-7-43 (b) W. M. McLaughlin, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4  
year 1943 hour 2:00 minute A M.  
21. I hereby certify that I attended the deceased from 1/8/41  
\_\_\_\_\_, 19\_\_\_\_, to 5/4/43, 19\_\_\_\_  
that I last saw im alive on 5/3/43, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary tuberculosis Duration 5 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1361  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. M. McLaughlin, M.D. (M. D. or other) \_\_\_\_\_  
Address Koch Hospital Date signed 5/4/43

**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 William Claude Gordon

Licensed Embalmer No. 3489

P. O. Address. 45-75 Aldine

**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.**