

FILED JUL 27 1943 18

Registration District No. _____

Primary Registration District No. 1062

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: Homer G. Phillips Hospital
(d) Length of stay: 3 days
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis, (d) Street No. 1221 So. 6th
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Albert Brock
3. (b) If veteran, name war no
3. (c) Social Security No. _____

4. Sex M 5. Color or race Negro
6. (a) Single, widowed, married, divorced 1
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Matthew

8. AGE Years 49 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation labor

11. Industry or business _____

12. Name Bellas Brock

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name Mitchell

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Stella Mitchell
(b) Address 1813 1/2 Ogden

17. (a) Burial _____ (b) Date thereof 7 13 43
(c) Place: burial or cremation Osaka Academy

18. (a) Signature of funeral director A. H. Baker
(b) Address JUL 1 1943
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

(Licensed Embellisher's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8, year 1943 hour 9 minute 20 P. M.
21. I hereby certify that I attended the deceased from July 5, 19 43 to July 8, 19 43, that I last saw him alive on July 8, 19 43, and that death occurred on the date and hour stated above.

Immediate cause of death: Autopsy: Pulmonary Abscesses, Pleural Effusion, Adhesive Pleuritis, Nephroclerosis
Cause 2 abscesses
Due to _____
Other conditions _____
Major findings: _____
Of operations _____
Of autopsy as above

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) _____ (e) Means of injury _____

23. Signature J. E. Smith (M. D. or other) _____
Address Boonville Date signed 7/13/43

Duration _____
Unk.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 6307

Registration District No. 318 Primary Registration District No. 1003

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

3. (a) PRINT FULL NAME Albert Brock
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 49 Months _____ Days _____ (Unless than one day) min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JUL 22 1943 (Date received local registrar) (b) J. F. Brebeck (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-22820