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7-5-17-39
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22825

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **6904**

FILED AUG 7 1943 318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

In this community 15 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 1324 924

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")

(d) Street No. 2931 Lemp
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Toney Brooks

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

4. Sex Male 5. Color or race 2 Negro 6. (a) Single, widowed, married, divorced Sep. /

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 27, 1908
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>35</u>	<u>2</u>	<u>4</u>	_____.hr. _____.min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER { 12. Name Tony Brooks

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

14. Maiden name Elizabeth Cole

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

FATHER { 16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier St.

17. (a) Antoniou (b) Date thereof 7/3/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JUL 30 1943
(Date received of local registrar)

J. J. [Signature]
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1, year 1943 hour 9 minute 15 A. M.

21. I hereby certify that I attended the deceased from June 23, 1943 to July 1, 1943 that I last saw him in alive on July 1, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Pulmonary Tuberculosis with cavitation

Duration Unk.

Due to _____

Due to _____

Other conditions 1/2 for!
(Includes 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) _____

(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 S. E. Smith (M. D. or other)
Address 2601 N. Whittier Date signed 7/3/43

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

32785

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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.....

..... Licensed Embalmer No.....

..... 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 above.