

JUL 24 1943 317

Registration District No. _____

Primary Registration District No. 3062

Registrar's No. 7680

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town St. Louis
(c) Name of hospital or institution 8601 Agnes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 17

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

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife Maggie Brown 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Dec 14 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Contract

11. Industry or business _____

12. Name Sam Brown

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

14. Maiden name Brown

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

16. (a) Informant Mr. M. Brown

(b) Address 4547 W. Lechard

17. (a) Buried (b) Date thereof 7-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Thomas Smith

(b) Address 4547 W. Lechard

19. (a) 7-30-43 (b) J. Mc Gray
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Brentwood
(If outside city or town limits, write "RURAL")
(d) Street No. 8601 Agnes
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1943 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan, 1942 to July 19, 1943
that I last saw him alive on July 18, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure

Due to Enlarged Heart

Due to Asphyx following Myocardial infarction

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

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) none

(b) Date of occurrence none

(c) Where did injury occur? none
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No Injury
While at work? No (Specify type of place) (e) Means of injury none

23. Signature E. J. Donnelly (M. D. or other)

Address 239 E. Kirkham Ave. Date signed 7-19-43

MOTHER FATHER

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. McNewell

Registered Apprentice No.....

working under my personal supervision.

Signed.....

William C. McNewell

Licensed Embalmer No.....

2114

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.