

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

ED OCT 2 - 1943

Registration District No. 317

Primary Registration District No. 2076

Registrar's No. 2158

1. PLACE OF DEATH: ST. LOUIS, CO.  
 (a) County ST. LOUIS, CO.  
 (b) City or town South Kinloch MO  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Jefferson 1st  
(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

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

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

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept day 22  
 year 1943 hour 1 minute 20 M.  
 21. I hereby certify that I attended the deceased from Sept. 20  
1943 to Sept. 22 1943  
 that I last saw her alive on Sept. 22 1943  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death: Lobar Pneumonia

4. Sex Female 5. Color or race negro  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife JACOB BROWN  
 6. (c) Age of husband or wife if alive 66 years  
 7. Birth date of deceased: 6 (Month) 1 (Day) 1888 (Year)

Duration 5 days  
 Physician \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

8. AGE: Years 55 Months 3 Days 22  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

10. Usual occupation House Wife

Major findings: 106  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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 JACOB BROWN

(b) Address JEFFERSON SO. KINLOCH

17. (a) Burial (b) Date thereof 9 25 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Boyd Brodhead  
 (b) Address LIX & SHERMAN St. Kinloch

19. (a) 9-25-43 (b) C. M. ...  
(Date received local registrar) (Registrar's signature)

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. P. ... (M. D. or other) M.D.  
 Address St. Louis, Mo. Date signed 9/27/43

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

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

*Louis V. Atkins*

Licensed Embalmer No. *2842*

P. O. Address. *3644 Finney Ave*

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.