

FILED NOV 29 1943
Registration District No. **378**

Primary Registration District No. **1003**

Registrar's No. **10012**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis,
(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 6 days (Specify whether years, months or days) 0
In this community 25 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County cap 219
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 3113a Delmar (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME William Brown

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased unavailable - abt. 1871
(Month) (Day) (Year)

8. AGE: Years abt. 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Janitor

11. Industry or business _____

12. Name Reuben Brown

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

14. Maiden name Laura Graham

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

16. (a) Informant Mrs. Allie Bowles

(b) Address 5617 Cabanne Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/1943
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) Nov 16 1943 (b) J. D. Bresick (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November, day 12, year 1943 hour 11 minute 15 P. M.

21. I hereby certify that I attended the deceased from November 6, 1943 to November 12, 1943, that I last saw him alive on November 12, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration Unk.

Due to _____

Due to _____

Other conditions (Include 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 _____

Signature Alva Moore (M. D. or other)

Address 2601 Wheeler Date signed 11/18/43

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

STATEMENT BY LICENSED EMBALMER

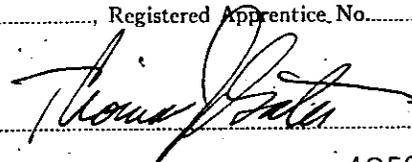
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

....., Registered Apprentice No.

working under my personal supervision.

Signed.....



Licensed Embalmer No. **4259**

P. O. Address **4107 Finney Avenue**

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See
Registrar's No. 10012

Registration District No. 318

Primary Registration District No. 1003

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

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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME William Brown
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 unknown
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 72 Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) DEC 1 1943 J. F. Budeck
(Date received local registry) (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 Nov 1943 Day 12 Minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... 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.....

Duration

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..... (M. D. or other)
Address..... Date signed.....

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