

S. No. 2
DM-5-43
v. 5-17-39
p. 1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39577

State File No. _____

FILED JAN 4 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11637

1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Little Sisters of the Poor - 5
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 2 years 5
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES BROOKS.

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased Feb. 17, 1858.
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Labored

11. Industry or business Retired

12. Name Frank Brooks

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

14. Maiden name Jenny Magland 9

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

16. (a) Informant Dorothy Finneson

(b) Address 1973 S. Memphis Ave

17. (a) Burial (b) Date thereof Mar. 24, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director J. J. Quinn

(b) Address 1389 Union Rd

19. (a) DEC 24 1943 (Date received local registrar) J. J. Quinn (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town St. Louis 920
(If outside city or town limits, write "RURAL")
(d) Street No. 3225 W. Chalmers Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21st
year 1943 hour 11 minute A .M.

21. I hereby certify that I attended the deceased from December 10 1943 to December 21 1943
that I last saw h. 1m alive on December 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Myocarditis 21.1

Due to 93

Other conditions: Acute upper respiratory infection 11 days
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None

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)
Cause of injury _____

23. Signature Donald H. Flott (M. D. or other) 11-23-43
Address 2317 Delahoussaye Date signed 11-23-43

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

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Harry J. Schumacher

Licensed Embalmer No.....

2679

P. O. Address.....

732 Longwood

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.