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M-8-43  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 20 1944  
Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
Primary Registration District No. 1003

12575  
State File No. \_\_\_\_\_  
Registrar's No. 3479

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

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 13 days (Specify whether  
In this community 40 years years, months or days)

3. (a) PRINT FULL NAME Willa C. Brandin  
3. (b) If veteran, name war 1-710 3. (c) Social Security No. don't know

4. Sex Male 5. Color or race 2 Negro 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Brandin 6. (c) Age of husband or wife if alive yes years  
7. Birth date of deceased Jan 17 (Month) (Day) (Year)

8. AGE: Years 40 Months 2 Days 23 hr. \_\_\_\_\_ min. If less than one day

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

10. Usual occupation  laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name W C Brandin  
13. Birthplace Myron Arkansas (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Myron Arkansas (City, town or county) (State or foreign country)

16. (a) Informant Sally Brandin  
(b) Address 2709 Bernard  
BRINKLEY ARK  
(c) Date thereof 4/15/44 (Month) (Day) (Year)  
(d) Place: burial or cremation Burial

18. (a) Signature of funeral director Thomas Vasile  
(b) Address 2812 Cass  
19. (a) APR 14 1944 (Date received local registrar) (b) J. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 0000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9  
(d) Street No. 2709 Bernard St. (If rural, give location) 22  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 9,  
year 1944 hour 7 minute 15 P. M.  
21. I hereby certify that I attended the deceased from March 27, 1944, to April 9, 1944  
that I last saw him alive on April 9, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Ulcers - at Pylorus  
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.

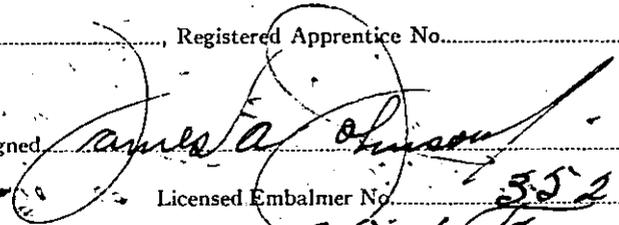
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature W. D. Johnston (M. D. certifier)  
Address Homer G. Phillips Hospital Date signed 4-10-44

**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. 3522

P. O. Address. 3506 Franklin

**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.**