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P-1 X37823

35184

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 24 1944

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 2116

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis County Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9/26 to 10/14/44.
(Specify whether)

In this community 11 years
years, months or days

3. (a) PRINT FULL NAME BROWN, DENNIS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race Colored

6. (a) Single, widowed, married, divorced widow?

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 26 1894
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 18 hr. _____ min. _____

9. Birthplace Larange, Texas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Landscaper gardener

11. Industry or business None

12. Name Lonnie Brown

13. Birthplace Franklin Co. Mo. 1
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Maloney 1

15. Birthplace Unknown 1
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Benbow 1

(b) Address 45 1/2 S Garfield Ave.

17. (a) Burial (b) Date thereof 10-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem. P.O. trash

18. (a) Signature of funeral director Page Boul

(b) Address 3847 Page Boul

19. (a) OCT 17 1944 (b) E. B. McLawrence M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 9

(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL.") 4

(d) Street No. 117 Agnew Ave
(If rural, give location)

(e) Citizen of foreign country? None (Yes or No)
If yes, name country None 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14
year 1944 hour 9 minute 50 A. M.

21. I hereby certify that I attended the deceased from Septembe
26, 1944, to Oct 14, 1944;
that I last saw him alive on Oct 14, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within months of death)

Major findings: Chronic Glomerular Nephritis

Of operations _____

Of autopsy: Arteriosclerotic Coronary vessels
Pugging, Shrunken Kidneys, Pleural Effusion

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?

(Specify type of place)

While at work? _____ (e) Means of injury 6

23. Signature John Mederunner (M. D. or other) MD
Address St. Louis County Hospital Date signed 10-18-44

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, 3847 Page Blvd., Registered Apprentice No. _____ working under my personal supervision.

Signed C. J. Nash
Licensed Embalmer No. 2439
P. O. Address 3847 Page Blvd.

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.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County
(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

3. (a) PRINT FULL NAME BROWN, Dennis

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

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

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 _____ Months _____ Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis
 (c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
 (d) Street No. 117 Agnew
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name the country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 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 Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy found at 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 John Mederunner (M. D. or other) MD

Address St. Louis Co. Hosp Date signed 11-22-47

USE BLUE INK—MAKE A PERMANENT RECORD

SPECIAL

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.....

P. O. Address.....

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.