

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. 6041

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 12 days
43 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4401 St. Ferdinand
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Andrew Brown

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

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

6. (b) Name of husband or wife Corneilla Brown 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Unavailable 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt. 65 hr. min.

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

10. Usual occupation Retired Blacksmith

11. Industry or business _____

MOTHER FATHER { 12. Name Mike Brown
13. Birthplace Unavailable 9
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothea Brockman
(b) Address 4401 St. Ferdinand Ave.

17. (a) Burial (b) Date thereof 7/12/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates
(b) Address 1107 Finney Ave.

19. (a) JUL 1 1945 (b) J. F. Finney
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9,
year 1945 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from June 27, 1945 to July 9, 1945
that I last saw him alive on July 9, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive Heart Disease

Duration
Unk.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 J. F. Finney (M. D. or other) _____
Address 2601 N. St. Louis Date signed 7/12/45

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

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.