

FILED AUG 3 1945

Registration District No. _____

818

Primary Registration District No. _____

1003

Registrar's No. _____

6667

1. PLACE OF DEATH

(a) County St Louis MO
(b) City or town St Louis MO
(c) Name of hospital or institution Hosp = 2
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State St Louis MO (b) County St Louis MO
(c) City or town St Louis MO (If outside city or town limits, write "RURAL")
(d) Street No. 2027 Walnut St (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

HERMAN BROWN

3. (b) If veteran, _____

3. (c) Social Security _____

Name war _____

No. _____

4. (a) Sex Male 5. Color Black 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 at death _____ 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 _____

MOTHER FATHER

12. Name Herman Brown

13. Birthplace St Louis MO (City, town, or county) _____ (State or foreign country)

14. Maiden name Herman Brown

15. Birthplace St Louis MO (City, town, or county) _____ (State or foreign country)

16. (a) Informant W. R. Hunter

(b) Address 3509 Rutledge

17. (a) Date of death JUL 9 1945 (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation Anatomical

18. (a) Signature of funeral director W. R. Hunter

(b) Address 3509 Rutledge

19. (a) JUL 30 1945 (Date received local registrar) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9 year 1945 hour 11 minute 15 AM

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 _____

Chronic Myocardial Infarction
Myocarditis
Coronary atherosclerosis
Chronic Pulmonary Disease

Other conditions _____ (Include pregnancy within 5 months of death)

Major findings: Of operations _____

Of autopsy _____

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) _____ Means of injury _____

23. Signature W. R. Hunter (M. D. or other) _____

Address 3509 Rutledge Date signed 7/25/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SEP 11 1964

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.