

FILED JUN 13 1948
318

1003

Registration District No.

Primary Registration District No.

Registrar's No. 4706

1. PLACE OF DEATH:

(a) County St Louis Mo.
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital No 10
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution 21 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis (If outside city or town limits, write "RURAL") 2147
(d) Street No. 1827 A Franklin Ave (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No) No
If yes, name country:

3. (a) PRINT FULL NAME

CHARLES BROOKS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced widow
6. (c) Age of husband or wife if alive about 18 28 years

8. AGE: Years About 68 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation laborer

11. Industry or business W.R.

12. Name W.R.

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

14. Maiden name W.R.

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

16. (a) Informant Lafayette Jackson

(b) Address Los Angeles Calif

17. (a) Removal (b) Date thereof MAY 27 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Los Angeles Calif

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

(b) Address Los Angeles Calif

19. (a) MAY 6 1948 (b) J. F. Bredeck (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1948 hour _____ minute _____

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 Septicemia perforated duodenum
Due to ulcer

Due to 111

Other conditions: (Include pregnancy within 3 months of death) 111

Major findings: Of operations _____

Of autopsy W.R.

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 time of day) _____ (Means of injury) _____

23. Signature Dr. Alfred J. Perry (M. D. or other) 3

Address 300 E. Main Ave Date signed _____

Emb Rep Cert to be filed

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.

[Signature]
Signed

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Charles Brook
3. (b) If veteran, name war..... 3. (d) Social Security No.....

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

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
at 68 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 5-26-1946 (b) J. F. Bredek
(Date received local registrar) (Signature)
JUN 29 1946

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 25
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Duration

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?
.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

18217