

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28495

State File No.

FILED AUG 20 1946
318

1003

Registrar's No. 6875

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6875

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:
624 N. Garrison Ave.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... (Specify whether
 In this community..... 50 yrs years, months or days)

3. (a) PRINT FULL NAME James Madison Brown

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

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife..... Maggie Brown 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased. November 20, 1967
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>12</u> hr. min.

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

10. Usual occupation Cook

11. Industry or business Missouri Pacific

MOTHER FATHER

12. Name George Brown 9

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

14. Maiden name Unknown 9

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

16. (a) Informant Maggie Brown
 (b) Address 624 N Garrison

17. (a) Burial (b) Date thereof 8/7/46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director C.W. Roberts

(b) Address 416 N. Taylor Ave
AUG 7 1946 (c) J. F. Bredeek
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 60
 (c) City or town St. Louis, Missouri 27
 (If outside city or town limits, write "RURAL")
 (d) Street No. 624 Garrison Ave.
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2
 year 1946 hour 8 minute 57 A.M.

21. I hereby certify that I attended the deceased from Aug
 / / 1937 to Aug / / 1946
 that I last saw him alive on Aug 15/46
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Coronary Arteriosclerosis
senility

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 9/3

Major findings:
 Of operations.....
 Of 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) Means of injury.....

23. Signature Dr. Boyd (M. D. or other) MD
 Address in St. Louis Date signed 8-24-46

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

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 Fulton G. Culkin

Licensed Embalmer No. 4698

P. O. Address Shelton 13 Mo.

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.