

FILED OCT 28 1946

STANDARD CERTIFICATE OF DEATH

State File No.

8905

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: Homer Phillips Hosp. S
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 days
(Specify whether in this community 2 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ooo

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 2-1-17

(d) Street No. 2030 Biddle St (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: Frank B. Brown

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 5. Color or race negro

6. (a) Single, widowed, married, divorced, Separated

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 1 1897
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
year 1946 hour 10 minute 5 A. M.

21. I hereby certify that I attended the deceased from Sept. 19 1946 to Oct. 14 1946; that I last saw him alive on Oct. 14 10:45 and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease with Mitral Insufficiency; Prob. Cirrhosis of Liver

Duration Undet.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: 124

Of operations _____

Of autopsy Yes

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years 49 Months 3 Days 13 If less than one day hr. min.

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

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER { 12. Name James Brown

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

14. Maiden name Martha Weaver

15. Birthplace Boliver Co. Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Williams

(b) Address 701 Webster madison

17. (a) Removal (b) Date thereof Oct 17 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St Louis Ill.

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

(b) Address 2205 Madison East St Louis Ill.

19. (a) OCT 17 1946 (Date received local registrar)

J. F. Brudeck (Registrar's signature)

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 E. B. Terrell (M. D. or other)

Address 2601 N Whittier Date signed 10/17/46

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed Ben. H. Baldwin
Licensed Embalmer No. 2420
P. O. Address Past Station

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8905-

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 Frank Brown

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

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive.....

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

8. AGE: Years 49 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) (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) (Date received local registrar) (b) J. F. Bredek (Registrar's signature) NOV 7 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 July Day 4
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....

that I last saw him..... 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.....

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.....

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

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

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A LEGIBLE COPY

MOTHER FATHER

34974