

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6066

State File No. _____

FILED MAR 11 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2013

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:
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. (Specify whether
In this community 18 YEARS years, months or days) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Evelyn Brown

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

4. Sex F 3. (a) Single, widowed, married, divorced SINGLE
5. Color or race Col

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

7. Birth date of deceased JULY 3 1928
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>18</u>	<u>7</u>	<u>21</u>	hr. min.

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

10. Usual occupation Nil

11. Industry or business _____

12. Name SAM BROWN

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

14. Maiden name CHARLENE

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

16. (a) Informant CHARLENE BROWN

(b) Address 3025 LACLEDE AVE

17. (a) BURIAL (b) Date thereof MAR 2 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FATHER DICKSON

18. (a) Signature of funeral director F. A. GREEN

(b) Address 2915 FRANKLIN AVE

19. (a) FEB 27 1947 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 3025 Laclede (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 24 day 24
year 1947 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from 2-12 1947, to 2-24 1947;
that I last saw her alive on Feb. 24 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy No

22. If death was due to external causes, fill in the following:

(c) 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) (or) Means of injury _____

Signature E. W. B. Williams (M. D. or other) _____

Address 2601 N Whittier Date signed 2/25/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

G. A. Greer

Licensed Embalmer No.....

2963

P. O. Address.....

2915 Franklin

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.