

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10608

State File No. 2801

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. _____

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 26 days
(Specify whether
in this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4326 Maffitt
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 12
year 1947 hour 5 minute 35 P. M.
21. I hereby certify that I attended the deceased from
2-14 1947, to 3-12 1947;
that I last saw her alive on Mar. 12 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of Colon with Metastasis
to Liver

Duration
Undet.

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

Major findings:

Of operations _____

Of autopsy Yes

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 Edw. B. Williams (M. D. or other)
Address 2601 N. Whittier Date signed 3/17/47

3. (a) PRINT FULL NAME Mamie Brown

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

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Sep

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

7. Birth date of deceased Feb. 6 1890
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Logan Crake

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

14. Maiden name Racheal Brown

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

16. (a) Informant W. Brown
(b) Address 4326 Maffitt Ave

17. (a) Removal (b) Date thereof March 17 1947
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation Temple Arkansas

18. (a) Signature of funeral director Samuel Smith

(b) Address 4326 Maffitt Ave

19. (a) _____ (b) J. F. Bredford
(Date received local registrar) (Registrar's signature)

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.....
Henry King....., Registered Apprentice No. 398
working under my personal supervision.

Signed *Lawrence E. Johnson*
Licensed Embalmer No. 4341
P. O. Address *St. Louis 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.