

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22094**
Registrar's No. **419**

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 12 1947
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH: **318**
(a) County **St. Louis**
(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 **3 mds** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **1003**
(a) State **Missouri** (b) County **Mad**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **21 2013 Franklin**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Rosa Brooks**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **3** year **1947** hour **4** minute **15 P** M.

4. Sex **Female** Color or race **Col**
5. (n) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **None**
6. (c) Age of husband or wife if alive **25** years
7. Birth date of deceased **July 25 1908**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 4**, 19**47**, to **July 3**, 19**47**; that I last saw her alive on **July 3**, 19**47**; and that death occurred on the date and hour stated above.

Immediate cause of death **Inoperable Carcinoma of Breast with Metastasis**
Due to **50**
Due to **50**
Other conditions **None**
(Include pregnancy within 3 months of death)

8. AGE: Years **38** Months **11** Days **8** If less than one day hr. min.

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

10. Usual occupation **Housework**

11. Industry or business
12. Name **Alex Cross**
13. Birthplace **Ark.**
(City, town, or county) (State or foreign country)

14. Maiden name **Rosa**
15. Birthplace **Ark.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rosa Cross**
(b) Address **Prague, Mo.**
17. (a) **Prague, Mo.** (b) Date thereof **7 10 47**
(Burial, cremation, or removal) (Month Day Year)
(c) Place: burial or cremation **Prague, Mo.**
18. (a) Signature of funeral director **A. J. Walter**
(b) Address **2715 S Ford**
JUL 7 1947
19. (a) **J. F. Bredek** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations
Of autopsy **No**
PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (Specify type of injury)
23. Signature **Stanton Phillips** or other
Address **2601 N Whittier** Date signed **7/5/47**

WRITE PLAINLY—USING 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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard ave.

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.