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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22923  
Registrar's No. 1488

Registration District No. 517 Primary Registration District No. 6076

1. PLACE OF DEATH:  
(a) County Sa nt Louis  
(b) City or town South Kinloch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
19 King Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 34 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME FRANK SHAPLEIGH BROWN  
3. (b) If veteran, name war None 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife Nora Brown 6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased July 27 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 11 17 hr. min.

9. Birthplace Saint Louis, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business unemployed

12. Name John Brown

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

14. Maiden name Eva Adams

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

16. (a) Informant Louise Sneed

(b) Address South Kinloch, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 47  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director Boyd Bros Funeral Home

(b) Address South Kinloch 21, Mo.

19. (a) 7-11-47 (Date received local registrar) (b) Carole J. Steyer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town South Kinloch  
(If outside city or town limits, write "RURAL")  
(d) Street No. 19 King Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 3  
year 1947 hour 1 minute 30 A. M.  
21. I hereby certify that I attended the deceased from June 30  
46 to July 3 47  
that I last saw him alive on July 2 47  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to Rheumatism 9 years

Other conditions 93R  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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)  
(e) Means of injury \_\_\_\_\_  
3. Signature J. R. Ramsey (M.D. or other) MD  
Address 19 King Street Date signed July 8, 1947

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

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**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

*Severin E. Erickson*

Licensed Embalmer No.

*434*

P. O. Address

*St. Louis 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.**