

FILED SEP 2 1947 318  
Registration District No.

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town ST. LOUIS, MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis Childrens Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-12-47 — 8-19-47  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County 999

(c) City or town FLORA 11  
(If outside city or town limits, write "RURAL")

(d) Street No. R.P. 0  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 2  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Cletis Katharine Brookheart

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19  
year 1947 hour 32 minute 25 P.M.

21. I hereby certify that I attended the deceased from 8-12-47 to 8-19-47  
that I last saw h. ex alive on 8-19-47  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 13 1939  
(Month) (Day) (Year)

Immediate cause of death Rheumatic myocarditis - chorea Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
<u>8</u>	<u>3</u>	<u>6</u>	<u>14</u> hr.	<u>25</u> min.

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

10. Usual occupation AT SCHOOL

11. Industry or business \_\_\_\_\_

12. Name James Brookheart

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

14. Maiden name NOT KNOWN

15. Birthplace NOT KNOWN 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Burke

(b) Address East St Louis Ill

17. (a) removal (b) Date thereof AUG 20, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flora, Ill

18. (a) Signature of funeral director Chas M. Burke

(b) Address East St Louis Ill

19. (a) AUG 20 1947 (b) J. F. Brodbeck  
(Date received by Registrar) (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 K. J. Batten (M. D. or other) \_\_\_\_\_  
Address St. Louis Ill Date signed \_\_\_\_\_

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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..... *Chas M. Burke* .....

Licensed Embalmer No. *2421* .....

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.**