No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 22 1947

Registration District No. 317

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 43781

Registrar's No. 2060

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 431 days (Specify whether years, months or days)

In this community: 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 000

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 22 South Theresa
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: BROWN, JENNIE MAE

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Female

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Separated

6. (b) Name of husband or wife: J. C. Brown

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

7. Birth date of deceased: June (Month) 24 (Day) 1923 (Year)

8. AGE:	Years	Months	Days	If less than one day
	24	5	15	hr. min.

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

10. Usual occupation: Nil

11. Industry or business:

FATHER
12. Name: Gal Watkins
13. Birthplace: (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name: Jennie Thompson
15. Birthplace: (City, town, or county) So. Carolina (State or foreign country)

16. (a) Informant: Hospital Records
(b) Address: Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenwood Cemetery

18. (a) Signature of funeral director: Felix Funeral Home
(b) Address: 2820 Stoddard St.

19. (a) 12-14-47 (Date received local registrar) (b) Cecilia Slaughter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9 year 1947 hour 3 minute 05 P. M.

21. I hereby certify that I attended the deceased from 12-4-46, 19..., to 12-9-47, 19...; that I last saw her alive on 12-9-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	2 yrs. (??)
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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? (e) Means of injury:

23. Signature: Bernard Friedman (M. D. or other) M.D.

Address: Robert Koch Hospital Date signed 12-10-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MAY 27 1948

APR 6 1948

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 Fulton E. Culkin

Licensed Embalmer No. 4198

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.