No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

941 State File No. 14918

FILED APR 30 1948

Registration District No. 277 Primary Registration District No. 3070 Registrar's No. 941

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Webster Groves (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: -/ (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether In this community 30 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St Louis 96
(c) City or town Webster Groves 7 (If outside city or town limits, write "RURAL")
(d) Street No. 805 Bell 4 (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Julius I Brooks
3. (b) If veteran, name war — —
3. (c) Social Security No. — —
4. Sex M 2
5. Color or race C
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife — —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 2 (Month) 7 (Day) 18 72 (Year)

8. AGE: Years 76 Months 2 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace St Genevie (City, town, or county) MO (State or foreign country) 11
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name John Brooks
13. Birthplace St Genevie (City, town, or county) Mo (State or foreign country) 11
MOTHER
14. Maiden name Elizabeth Leason
15. Birthplace St Genevive (City, town, or county) Mo (State or foreign country) 11
16. (a) Informant Luella Robinson
(b) Address 6331 Wagner
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/28 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dixon
18. (a) Signature of funeral director Lewis Funeral
(b) Address 22 Euclid
19. (a) 4-12-48 (Date received local registrar) (b) Carl A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 10 year 1948 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 4/8, 1948 to 4/10, 1948; that I last saw him alive on 4/10, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma — Duration 2-Days

Due to ------ 95c

Due to .....

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

Major findings:
Of operations None
Of autopsy None

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) NO
(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 [signature] (M. D. or other)
Address 177 E. Kirkham Date signed 4-12-48 Webster Groves Mo

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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. A P Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 317 Primary Registration District No. 3070 Registrar's No. 941

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Webster Grove
(If outside city or town limits, write "RURAL" and name of township)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Julius 2. Brooks

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 7 (Month) 1873 (Day) (Year)

8. AGE: Years 76 Months 2 Days 3 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Apr 1 Day 1940
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-14918