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FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9854

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2141

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis, Mo
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOMER G. PHILLIPS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
d. STREET ADDRESS (If rural, give location) 2326 Lasalle

3. NAME OF DECEASED (Type or Print)
a. (First) Leroy
b. (Middle)
c. (Last) Brown

4. DATE OF DEATH (Month) Mar. (Day) 3 (Year) 1949

5. SEX Male
6. COLOR OR RACE Col.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Jan 10 1922
9. AGE (In years last birthday) 27
If under 1 year: Months 1 Days 1
If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY Hotel
11. BIRTHPLACE (State or foreign country) Jackson Tenn
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Leroy Brown
13b. MOTHER'S MAIDEN NAME not known
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Jennie Neal **ADDRESS** 2326 Lasalle

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Undet.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Undetermined

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* None

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-20, 1949, *to* 3-3, 1949, *that I last saw the deceased alive on* 3-3, 1949, *and that death occurred at* 12:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Herbert J. Ettwein (Degree or title) M. D.
23b. ADDRESS 2601 N Whittier
23c. DATE SIGNED 3-5-49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 3-8-49
24c. NAME OF CEMETERY OR CREMATORY Oak Hill
24d. LOCATION (City, town, or county) Lemay, Mo (State)

DATE REC'D BY LOCAL REGIS. MAR 8 1949
REGISTRAR'S SIGNATURE J. B. Kasater
25. FUNERAL DIRECTOR'S SIGNATURE D J Watson **ADDRESS** 2769 Choteau

(Licensed Embalmer's Statement on Reverse Side)

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

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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Signed S J Watson

Signed .....
Student Embalmer

Licensed Embalmer No. 2698

P. O. Address 2769 Route

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.