

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2089

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No.			
1. PLACE OF DEATH a. COUNTY Missouri				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY 020					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place) 18 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17					
d. FULL NAME OF HOSPITAL OR INSTITUTION Mason Cox Hospital				d. STREET ADDRESS (If rural, give location) 5351 Delmar 0					
3. NAME OF DECEASED (Type or Print)			a. (First) Mary		b. (Middle) Susan		c. (Last) Brown		
4. DATE OF DEATH		(Month) 3		(Day) 5		(Year) 49			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 4-3-1871			
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months 11 Days 2		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Pike County, Missouri			
12. CITIZEN OF WHAT COUNTRY			13a. FATHER'S NAME J. S. Worledge		13b. MOTHER'S MAIDEN NAME Sarah E. Smith		14. NAME OF HUSBAND OR WIFE William Henry Brown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Rothe, 5351 Delmar, St. Louis					
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; ashenia; etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cirrhosis of Liver				DUE TO (c)				6 Mo	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION 5810	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 31, 1931 , to Mar. 5, 1949 , that I last saw the deceased alive on Mar. 5, 1949 , and that death occurred at 4:30A m. , from the causes and on the date stated above.									
23. SIGNATURE (Degree or title) Robert Carson M.D.				23b. ADDRESS Metropolitan Bldg., St. Louis		23c. DATE SIGNED 3-5-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/7/49		24c. NAME OF CEMETERY OR CREMATORY Prairieville		24d. LOCATION (City, town, or county) (State) Rolla, Missouri			
DATE REC'D BY LOCAL MAR 5 1949		REGISTRAR'S SIGNATURE J. B. Losate		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd			

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Robert M Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo*

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

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