

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42312

318

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State File No. ....

Registrar's No. 11064

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (In this place) 23 YRS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3834 LAFAYETTE AVENUE		d. STREET ADDRESS (If rural, give location) 3834 LAFAYETTE AVENUE	
3. NAME OF DECEASED a. (First) ANNA		b. (Middle) BELLE	
c. (Last) BROWN		4. DATE OF DEATH DECEMBER 22, 1949	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH Jan. 30, 1886
9. AGE (In years last birthday) 63		10. UNDER 1 YEAR Months Days	11. UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) PARRISH, ILLINOIS
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME JAMES AKIN	
13b. MOTHER'S MAIDEN NAME ANGELINE OSBORNE		14. NAME OF HUSBAND OR WIFE CLIFFORD	

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 RAY BROWN	
		ADDRESS 3834 LAFAYETTE AVENUE	

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma, Breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	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	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) <u>50</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>170X</u>

22. I hereby certify that I attended the deceased from 10-10, 1949, to 10-22, 1949, that I last saw the deceased alive on 10/20, 1949, and that death occurred at 6:45 m., from the causes and on the date stated above.

23a. SIGNATURE <u>B. U. Hunter MD</u>	(Degree or title)	23b. ADDRESS <u>5600 S Compton</u>	23c. DATE SIGNED <u>12/23/49</u>
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24a. BURIAL CREMATION REMOVAL (Specify) BURIAL	24b. DATE 12-24-49	24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI
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DATE REC'D BY LOCAL REG. DEC 24 1949	REGISTRAR'S SIGNATURE <u>J. B. Sasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Allen H. McLaughlin</u>	ADDRESS <u>2501 Lafayette</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

DR. CHAS. NESTER  
5600 SO. COMPTON AVE

*Embalmer*

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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 *C. W. Cooper*

Licensed Embalmer No. *3830*

P. O. Address *2301 Lafayette*

**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.