

FILED FEB 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6944

State File No. _____

352

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3063** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY ST. LOUIS			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN CLAYTON)		c. LENGTH OF STAY (in this place) 1 DAY	c. CITY (If outside corporate limits, write RURAL and give township) 31 TOWN WELLSTON		11310
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSPITAL			d. STREET ADDRESS (If rural, give location) 6218 WAGNER		
3. NAME OF DECEASED (Type or Print) a. (First) GEORGIA		b. (Middle) ANN	c. (Last) BROWN	4. DATE OF DEATH (Month) (Day) (Year) FEB. 8 1950	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH OCT. 12, 1948	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) POCAHONTAS, ARK.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME CLIFFORD BROWN		13b. MOTHER'S MAIDEN NAME ELWANDA MASSEY		14. NAME OF HUSBAND OR WIFE NONE	
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 CLIFFORD BROWN - 6218 WAGNER		

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningiococemia		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid 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.		0591

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	057.1
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	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 **2-7-1950**, to **2-8-1950**, that I last saw the deceased alive on **2-8-1950**, and that death occurred at **11:25 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William H. Crouch Jr. M.D.		23b. ADDRESS 601 Benton Clayton	23c. DATE SIGNED 2/9/50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-9-50	24c. NAME OF CEMETERY OR CREMATORY POCAHONTAS, ARK.	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL FEB 9 1950	REGISTRAR'S SIGNATURE Herbert H. Womde, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert H. Hoppe, 4700 Washington	
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(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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3653

P. O. Address _____

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.