

FILED JAN 31 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2383
654
State File No.

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

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. Louis** c. LENGTH OF STAY (in this place) **20 yrs**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. Louis** **2119**

d. FULL NAME OF HOSPITAL OR INSTITUTION **8th & 6th Street**

d. STREET ADDRESS (If rural, give location) **4233, West Belle. Place**

3. NAME OF DECEASED
a. (First) **Cleophas** b. (Middle) **A** c. (Last) **Brown**

4. DATE OF DEATH (Month) (Day) (Year) **I / 19 / 1951**

5. SEX **Male 2**

6. COLOR OR RACE **Col.**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Single**

8. DATE OF BIRTH **3 / 21st / 1928**

9. AGE (In years last birthday) (Months) (Days) **22 10 28**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Cook in Hotel**

10b. KIND OF BUSINESS OR INDUSTRY **York Hotel**

11. BIRTHPLACE (State or foreign country) **Cotton Plant, Arkansas**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Melvin. Brown**

13b. MOTHER'S MAIDEN NAME **Genevia Ivory**

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) **no None**

16. SOCIAL SECURITY NO. **494-26-8887**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Genevia Brown 4233, West. Belle. Pl**

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) _____
ANTECEDENT CAUSES
DUE TO (b) **Pulmonary Congestion**
DUE TO (c) **Cardiac Hypertrophy**
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
INTERVAL BETWEEN ONSET AND DEATH _____

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES 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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **H343**

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:49 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **John H. Houston**

23b. ADDRESS **1300. Clark**

23c. DATE SIGNED **1/20/51**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial 11**

24b. DATE **1/25/51**

24c. NAME OF CEMETERY OR CREMATORY **Greenwood Cemetery**

24d. LOCATION (City, town, or county) (State) **ST. Louis, Missouri**

DATE FILED BY LOCAL REGISTRAR'S SIGNATURE **J.P. Laster**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **John H. Houston 2829, Washington. B.P.**

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

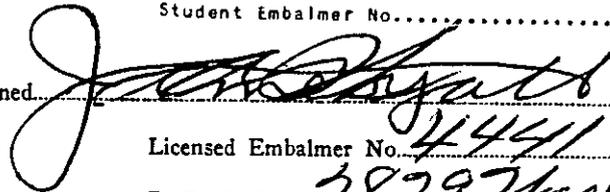
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....



Signed.....
Student Embalmer

Licensed Embalmer No. 4441

P. O. Address 2829 Washington

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.