

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILE MAR 7 1951

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1886

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Missouri</u> b. COUNTY	
b. CITY OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u> <u>2107</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4174a Farlin Ave.</u>		d. STREET ADDRESS (If rural, give location) <u>4174a Farlin Ave.,</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>James</u>	b. (Middle) <u>W.</u>	c. (Last) <u>Brown.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 25 1951</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED? (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Jan. 31-1880</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Mtn.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Postal Employ</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>Wm. E. Brown.</u>	13b. MOTHER'S MAIDEN NAME <u>Sallie Collins</u>	14. NAME OF HUSBAND OR WIFE <u>Olga E. Brown.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Olga E. Brown.</u> ADDRESS <u>4174a Farlin Ave.</u>
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis of Lungs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		
	DUE TO (c) <u>Hypertension</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>			<u>525X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK? <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug. 1954 to 2-25, 1957, that I last saw the deceased alive on Feb. 24, 1957, and that death occurred at 3 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Samuel Leibov</u> (Degree or title) <u>Dr.</u>	23b. ADDRESS <u>5329 Riverview</u>	23c. DATE SIGNED <u>2/26/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-28-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>
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DATE REC'D BY LOCAL <u>FEB 26 1957</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Leidner Und. Co.</u> ADDRESS <u>2223 St. Louis Av</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

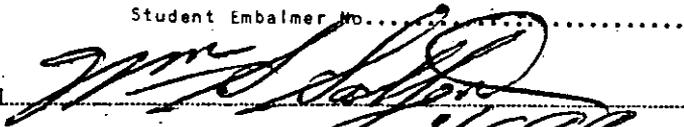
STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student Embalmer No.

Signed.....



Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, Mo.

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.