

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25612

State File No. 6405

EMD JUL 28 1952

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6405	
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) St. Louis		c. LENGTH OF STAY (in this place) 4 1/2 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2199 d	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary				d. STREET ADDRESS (If rural, give location) 19 4018 Enright Avenue 2nd Fl			
3. NAME OF DECEASED (Type or Print) Josie		a. (First)		b. (Middle) Brown		c. (Last)	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 9/26/1886	
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months 9 Days 5		IF UNDER 1 HR. Hours _____ Min. _____		4. DATE OF DEATH (Month) (Day) (Year) 7/1/52	
10a. USUAL OCCUPATION (Specify kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (State or foreign country) Port Gibson, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Willison Bridges		13b. MOTHER'S MAIDEN NAME Martha J. Holt		14. NAME OF HUSBAND OR WIFE Walter Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beuna McDaniels, 4018a Enright Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Heat stroke		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heat stroke				INTERVAL BETWEEN ONSET AND DEATH 6-29-52	
*This does not mean the mode of dying, such as heart failure, asphyxiation, etc. It means the disease, injury, or complication which caused death.		II. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Left Hemiplegia				JAN. 1951	
		DUE TO (c) Right Hemiplegia				JAN. 1951	
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., to or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
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? E 9319			
22. I hereby certify that I attended the deceased from 6-29-1952 , to 7-1-1952 , that I last saw the deceased alive on _____, 19____, and that death occurred at 4:50 P m., from the causes and on the date stated above. 4/6							
23a. SIGNATURE Julius C. Shepard, M.D.				23b. ADDRESS 2702a Franklin Avenue		23c. DATE SIGNED 7-2-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7/5/52		24c. NAME OF CEMETERY OR CREMATORY Jackson, Mississippi		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. JUL 3 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chas. J. Gates, 4107 Finney Avenue			

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

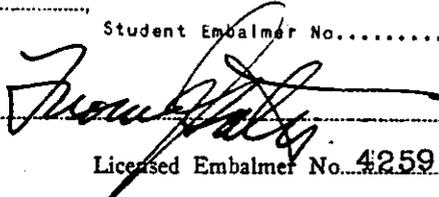
STATEMENT BY LICENSED EMBALMER

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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....


Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.