

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **40011**
Registrar's No. **10257**

FILED DEC 2 1952

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) 12 yrs. d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary			2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission.) a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 3632 N. Taylor Avenue		
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3. NAME OF DECEASED (Type or Print) Floy Brown a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) 11/5/52				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5/5/93	9. AGE (In years last birthday) 59	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) Marshall, Illinois	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Chas. S. Smith	13b. MOTHER'S MAIDEN NAME Nellie J. Mitchell	14. NAME OF HUSBAND OR WIFE Russell Brown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS _____ Rev. Russell S. Brown, 3632 N. Taylor
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease DUE TO (c) Diabetes Mellatus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____
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? 260X

22. I hereby certify that I attended the deceased from 2/20, 1952, to 11/5, 1952, that I last saw the deceased alive on 11/5, 1952, and that death occurred at 10:00am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. E. Smith M.D.	23b. ADDRESS 11 N. Jefferson	23c. DATE SIGNED 11/7/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/8/52	24c. NAME OF CEMETERY OR CREMATORY Xenia, Ohio	24d. LOCATION (City, town, or county) (State) _____
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DATE REC'D BY LOCAL REG. NOV 7 1952	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____ Chas. J. Gates, 4107 Finney Avenue
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M. J. P. (Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

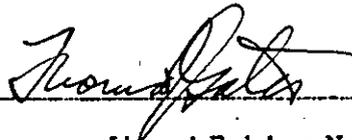
Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed



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.