

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH43311
State File No. _____
11128
Registrar's No. _____

DEC 24 1952

318

1003

BIRTH NO. _____

REG. DIST. NO. _____

PRIMARY REG. DIST. NO. _____

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)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2119
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			d. STREET ADDRESS (If rural, give location) 4183 Enright		
3. NAME OF DECEASED (Type or Print) a. (First) Goldie b. (Middle) Leo c. (Last) Brown			4. DATE OF DEATH Dec. 1 1952		
5. SEX 2 Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH MAY 27, 1894	9. AGE (In years) 58	IF UNDER 1 YEAR Months 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER	10b. KIND OF BUSINESS OR INDUSTRY CLEANERS	11. BIRTHPLACE (City and State or Foreign Country) COULTERVILLE, ILLINOIS		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME ANTWINE BROWN		13b. MOTHER'S MAIDEN NAME SARAH REID		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) yes WORLD WAR I		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Ophelia Conners		
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Bladder, Far advanced Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Extensive Decubiti			ADDRESS 4149 WASHINGTON
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)		181X
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?			
22. I hereby certify that I attended the deceased from 9-29, 19 52, to 12-1, 19 52, that I last saw the deceased alive on 12-1, 19 52, and that death occurred at 11:55a m., from the causes and on the date stated above.					
23a. SIGNATURE Herbert A. Harris M. D.			23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 12-2-52
24a. BURIAL, CREMATION, TOWN, REMOVAL (Specify)	24b. DATE 12-5-52	24c. NAME OF CEMETERY OR CREMATORY SPARTA		24d. LOCATION (City, town, or county) (State) ILB	
DATE REC'D BY LOCAL REG. DEC 3 1952	REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE M. A. F. WALTON		
			ADDRESS 2707 STODDARD ST.		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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

Arthur L. Heald

Licensed Embalmer No. 4221

P. O. Address 4524 Aldene

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.