

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

State File No. **9913**  
Registrar's No. **2798**

BIRTH NO. **FILED APR 2 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>2127</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>12. <del>123</del> 834 N. Kingshighway</b>	

3. NAME OF DECEASED (Type or Print) <b>CHARLES</b>	a. (First)	b. (Middle)	c. (Last) <b>BROWN</b>	4. DATE OF DEATH <b>March 27, 1954</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept. 28, 1889</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Photography</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Russia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Unknown Brown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Bessie Brown</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME / ADDRESS <b>Bessie Brown 834 N. Kingshighway</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>		4 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) <b>Pulmonary emphysema</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Uremia</b>		5 days	

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) <b>420.0</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input 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 **1850**, to **Year 27, 1954**, that I last saw the deceased alive on **Mar 27, 1954**, and that death occurred at **8 P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Lawrence M. Kotowicz MD</b>	23b. ADDRESS <b>4409 W. Olive</b>	23c. DATE SIGNED <b>3/28/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3/28/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>	24d. LOCATION (City, town, or county) (State) <b>Univ. City, Mo</b>
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DATE REC'D BY LOCAL REG. <b>MAR 29 1954</b>	REGISTRAR'S SIGNATURE <b>J. Charles Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Berger Memorial</b>	ADDRESS <b>4715 McPherson</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

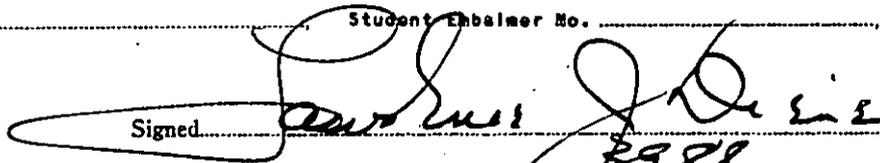
No. 300  
10-48

**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 .....  
Student Embalmer

Signed  \_\_\_\_\_  
Licensed Embalmer No. 8988

P. O. Address \_\_\_\_\_

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.