

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35183**

FILED OCT 26 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9104**

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, MISSOURI**

c. CITY OR TOWN **St. Louis**

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **BARNES HOSPITAL**

e. STREET ADDRESS **5475 Cabanne Ave** 205/0

3. NAME OF DECEASED  
a. (First) **JAMES** b. (Middle) **ALEXANDER** c. (Last) **BROWN**

4. DATE OF DEATH **October 5, 1954**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **Nov. 25, 1881**

9. AGE (In years last birthday) **72**  
# OVER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_ # OVER 100 HOURS Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Dentist**

10b. KIND OF BUSINESS OR INDUSTRY **surgical**

11. BIRTHPLACE (City and State or Foreign Country) **St. Louis, Missouri**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **James Brown**

13b. MOTHER'S MAIDEN NAME **Sarah Peterkin**

14. NAME OF HUSBAND OR WIFE **Helen Fischer Brown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** (If yes, give way or dates of service) **W.W. I**

16. SOCIAL SECURITY NO. **490-38-7609**

17. INFORMANT'S SIGNATURE OR NAME **John E. Milne** ADDRESS **4426a Red Bud Ave. 15**

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.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Carcinoma of Colon with metastases**  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
**6 mos.**

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **153x**

22. I hereby certify that I attended the deceased from **9-4-**, 19**54**, to **10-5-**, 19**54**, that I last saw the deceased alive on **10-5-**, 19**54**, and that death occurred at **8:42 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE **R. V. Bradley** (Degree or title) **M. D.**

23b. ADDRESS **BARNES HOSPITAL**

23c. DATE SIGNED **10-6-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Cremation**

24b. DATE **10/8/1954**

24c. NAME OF CEMETERY OR CREMATORY **Oak Grove Crematory**

24d. LOCATION (City, town, or county) **St. Louis Co., Missouri** (State) \_\_\_\_\_

DATE REC'D BY LOCAL REG. **OCT 7 1954**

REGISTRAR'S SIGNATURE **J. Carl Smith**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **C.R. Lupton & Sons; 7233 Delmar Blvd.**

(Licensed Embalmer's Statement on Reverse Side)

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *48*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.