

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35184
8525

State File No. 35184
Registrar's No. 8525

FILED OCT 26 1954

318

1003

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 12 5048 ENRIGHT	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5048 ENRIGHT			

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) JOSEPHINE	c. (Last) BROWN	4. DATE OF DEATH (Month) (Day) (Year) 9 16 1954
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH Feb. 5, 1876	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME JAMES SLOWEY	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE FRANK 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) nil	16. SOCIAL SECURITY NO. nil	17. INFORMANT'S SIGNATURE OR NAME Mrs. Nancy Willson	ADDRESS 5048 Enright
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocarditis (chronic) 1 yr?		
	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. acute Gall Bladder Disease & cholelithiasis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 2 jaundice	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)
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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? 4222
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22. I hereby certify that I attended the deceased from **Sept 2, 1954** to **9-15, 1954** that I last saw the deceased alive on **9-15, 1954** and that death occurred at **5 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Lucas R. Reel	(Degree or title)	23b. ADDRESS 730 Hodeman	23c. DATE SIGNED 9-17-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 9-18-54	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST. LOUIS
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DATE REC'D BY LOCAL REG. SEP 17 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Lucy Mullen	ADDRESS 5041 Belmont
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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 *John D. Deakley*

Licensed Embalmer No. *3653*

P. O. Address *St Louis Mo*

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.