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FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16491**
Registrar's No. **4323**

BIRTH NO. _____ 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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) E. c. (Last) BROWN		4. DATE OF DEATH (Month) (Day) (Year) MAY 15, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan 15, 1888
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	11. BIRTHPLACE (City and State or Foreign Country) Ogala Nebr.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Arrow Press	
11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? Am.	
13a. FATHER'S NAME Frank Brown		13b. MOTHER'S MAIDEN NAME Dora Taylor	
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) No	
16. SOCIAL SECURITY NO. 444-07-7807		17. INFORMANT'S SIGNATURE OR NAME Mabel Thomas	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of larynx with metastases and cachexia 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ADDRESS	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 161X	
22. I hereby certify that I attended the deceased from 11-12-54 , 19____, to 5-15-55 , 19____, that I last saw the deceased alive on 5-15-55 , 19____, and that death occurred at 5:30P m., from the causes and on the date stated above.			
23a. SIGNATURE <i>[Signature]</i>		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 5-16-55		24. LOCATION (City, town, or county) (State)	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-17-55	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County	
DATE RECD BY LOCAL REG. MAY 16 1955		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> Fred C. Henke	
REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS 4911 Washington Blvd	

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 *M. W. Wilkins*

Licensed Embalmer No. *3*

P. O. Address *M. L.*

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.