

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6344

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1093**

City **St Louis Mo.** (No. **Barnes Hospital**)

File No.

Registered No. **1505**

St. Ward)

2. FULL NAME **James Randolph Brown**

(a) Residence. No. **Perry Mo.** St. **12** Ward. **Perry Mo.**

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Dec 14 1900

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
26	2		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Filling station attendant**
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer **Standard Oil Co.**

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

John E. Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Emilia Vandeventer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT (Address)

John E. Brown Perry, Mo.

15.

FILED **11 1927**

Man. C. Starcoff

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

2 - 14 1927

17.

I HEREBY CERTIFY, That I attended deceased from **2 - 7 1927**, to **2 - 14 1927** that I last saw him alive on **2 - 14 1927**, and that death occurred, on the date stated above, at **1 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Myelogenous Leukemia

65 776 1316 1326 (duration) mos. da.

CONTRIBUTORY (SECONDARY)

Carbuncle of buttock
Bursitis of knee (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Geo. Neesche** M. D.

, 19 (Address) **Barnes Hospital**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Perry Mo. Feb 17 1927

20. UNDERTAKER

ADDRESS

Philander Craig King Highway 12 38

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

