

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

Do not use this space.

13798

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City St. Louis Mo. (No. at Residence)

File No.....

Registered No. 4154

St.....

Ward.....

2. FULL NAME

Annie Brown

(a) Residence, No. 2124 gratiot St. 22 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Col. Married

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

5A. IF MARRIED, WIDOWED, OR DIVORCED

X HUSBAND OF Robert Brown
(OR) WIFE OF

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

Not Known

7. AGE

YEARS

MONTHS

DAYS

.If LESS than 1 day, hrs. or min.

about 49

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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife 175

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Jackson Tenn

10. NAME OF FATHER

Will Quinn

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Jackson Tenn

12. MAIDEN NAME OF MOTHER

Henia Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14.

INFORMANT

(Address)

Geo Quinn 202 St. Louis Ave

15.

FILED MAY -2 1927

Max Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-19-27 19

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 9-40 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Internal Ruptured
air fight (fight) mos. da.
CONTRIBUTORY (SECONDARY) = = = = = suicide
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm Dwyer
4/30, 1927 (Address) Dep Coroner

*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

Washington Park May 3 1927

20. URDERTAKER

ADDRESS

Quinn Bros. Jeff. Ave 2152

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.

