

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

Do not use this space.

20245

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **City Hosp. W.R.**) St. Ward)

File No.
 Registered No. **6052**

2. FULL NAME

Allen Brown
 (a) Residence. No. **3331 Market**, St. **21** Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred **4** 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 **Negro** 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) **Nov. 13, 1901**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 | **6** | **18**

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **nil.**
 (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) **La.**

10. NAME OF FATHER **Alfred Brown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Miss**

12. MAIDEN NAME OF MOTHER **Nancy Gilmore**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Miss**

14. INFORMANT (Address) **August Woodard City Hospital #2**

15. FILED **JUN 30 1927** **Small & Starkoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 1, 1927**

17. I HEREBY CERTIFY, That I attended deceased from **16** to **June 1, 1927** and that I last saw him alive on **June 4, 1927** and that death occurred, on the date stated above, at **4:30** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aneurysm - ascending aorta

9/6 (duration) yrs. 9 mos. da.

CONTRIBUTORY (SECONDARY) **9/10** (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRAICTED IF NOT AT PLACE OF DEATH?

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

19. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Chemical & histology**
 (Signed) **J. W. Gray**, M. D.
 , 19 (Address) **City Hosp. Mo.**

*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 **Washington** DATE OF BURIAL **6/3/27**

20. UNDERTAKER **W. Richter 3500 Kutzer** ADDRESS

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.

