

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

Do not use this space.

3468

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis* (No. ....)

Registration District No. *791*  
Primary Registration District No. *1003*

File No. *1103*  
Registered No. ....  
St. .... Ward

**2. FULL NAME** *John Hanna Brown*

(a) Residence, No. *5351 Delmar* St., *12* Ward.

(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) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Don't know*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 9 - 1851*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*76 3 19*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *retired*  
(b) General nature of industry, business, or establishment in which employed (or employee) *Trav. Salesman*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Cincinnati* (STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Christine H Brown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Rebecca Dobb*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

14. INFORMANT *Hilmoth Waller* (Address) *5351 Delmar Blvd.*

15. FILED *30* 19*28* *Mar 6 Starckoff* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 28* 19*28*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 10*, 19*28* to *Jan 28*, 19*28* that I last saw him alive on *Jan 28*, 19*28*, and that death occurred, on the date stated above at *945 P.M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Asthenia Nephrosi*

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? *D. J. Bi* (Signed) *Liter Bldg.* M. D.

*729* 19*28* (Address)

\*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

*Louisville Ky* *2-1* 19*28*

20. URBERTAKER ADDRESS

*Henry Neir 2223 S. Grand*

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.

THIS IS A PERMANENT RECORD

