

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

Do not use this space.

10759

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *1392*) *Montclair*

File No.

Registered No. **2578**

St. Ward)

2. FULL NAME

(a) Residence. No. *Morris Brown* St. *6* Ward. *Killespie Ills.*

(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) *widower*

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *ab 60*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Shoe merchant* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Korno* (STATE OR COUNTRY) *Russia*

10. NAME OF FATHER *Abraham Brown*

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

12. MAIDEN NAME OF MOTHER *unk*

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

14. INFORMANT *Mrs Elizabeth Silberstein* (Address) *1392 Montclair*

15. FILED *7-7-28* *Mary S. Yarncoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 6 19 28*

17. I HEREBY CERTIFY That I attended deceased from *March 2, 1928* to *March 6, 1928* that I last saw him alive on *March 6, 1928* and that death occurred, on the date stated above, at *11 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Intestinal Hepatitis

131 *R.I.D.* (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Cerebral Apoplexy* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *1270* *Killespie Ills.* IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Nathaniel Goldberg* (Address) *4724 Brookfield*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Beth Ham Hag* DATE OF BURIAL *3/8 1928*

20. UNDERTAKER *H. B. Berger* ADDRESS *4724 Brookfield*

K. 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

