

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **7011**

Township.....

Primary Registration District No. **05**

City **St. Louis** (No. **City of St. Louis**)

File No. **22405**

Registered No. **6597**

St. **Ward**

2. FULL NAME

(a) Residence. No. **14th & Oak St.** St. **Ward.**
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **10** yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 26 - 1903**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 — **24**

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) **Marie**
(STATE OR COUNTRY)

10. NAME OF FATHER **Charles J. Brown**

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address) **Charles J. Brown**
City of St. Louis

15. FILED **23 1028** **May 27 1928** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 19 1928**

17. I HEREBY CERTIFY That I attended deceased from **June 3 1928** to **June 19 1928**, that I last saw him alive on **June 19 1928**, and that death occurred, on the date stated above, at **8:25 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

Bilateral Paralysis, causative (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Organism unknown.** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Robert A. Simpson** M.D.
6/19/28 (Address) **City of St. Louis**

*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 Cem.

6/23 1928

20. UNDERTAKER

ADDRESS

W.B. Gordon Und. Co.

2649 Morganst

Carroll

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City..... (No.....)

Registration District No.....
Primary Registration District No.....

File No.....
Registered No.....
St..... Ward.....

2. FULL NAME

(a) Residence. No..... St..... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED AUG 10 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
Bilateral Paralysis
Causative organism not
Thumps, information given over
Phone by Rev. Robt Simpson, Sec. of H. S.
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) 908, M. D.
, 19 (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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE FEES FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-24405