

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

Do not use this space.

31898

**1. PLACE OF DEATH**

County..... Registration District No. *701*  
 Township..... Primary Registration District No. *1032*  
 City *St Louis* (No. *St Anthony Hosp*)

File No.....  
 Registered No. *8903*  
 St. Ward

**2. FULL NAME**

*Infant Browne*  
 (a) Residence. No. *5401 Keege Road* St. *St. Louis* as *Mo* Ward. *16*  
 (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 *male* 4. COLOR OR RACE *white* 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) *Sept 1 - 1929*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, *12* hrs. or *30* 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) *St Louis*  
 (STATE OR COUNTRY) *mo*

PARENTS  
 10. NAME OF FATHER *Chas A Browne*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St Louis*  
 (STATE OR COUNTRY) *mo*  
 12. MAIDEN NAME OF MOTHER *Betty Sanders*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St Louis*  
 (STATE OR COUNTRY) *mo*

14. INFORMANT *Chas J Browne*  
 (Address) *5400 Keege Road*

15. FILED *SEP 2 19 1929* *Max C Starker* REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 1 19 29*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 1 1929* to *Sept 1 1929* that I last saw him alive on *Sept 1 1929* and that death occurred, on the date stated above, at *1:30* p.m.

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

*Respiratory failure*  
*Premature about 8 mo*  
*15 7* (duration) yrs. mos. *4 1/2* hrs  
 CONTRIBUTORY *15 7*  
 (SECONDARY) *16/19* (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) *Adam Levingman* M. D.

\*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 *Calvary Cem* DATE OF BURIAL *Sept 2 19 29*

20. UNDERTAKER *Thomas J Livan* ADDRESS *12519 St Louis*

