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

Do not use this space. ~~3194~~ ~~3004~~ 3635

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St Louis (No. City Hospital St. ..... Ward)

File No.....

Registered No. 1835

2. FULL NAME 12519 James Brown

(a) Residence. No. Municipal Lodging Hmsl St. Ward. 25
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 45 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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 22 - 1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	64	10	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nor Kum

(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) Illinois

PARENTS

10. NAME OF FATHER Wm Brown

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

12. MAIDEN NAME OF MOTHER Mary Trim

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

14. INFORMANT Hospital Information

(Address) City Hospital

15. FILED ..., 19.. Max C. Hawley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929 to Jan 26, 1930 that I last saw h. Dm alive on Jan 26, 1930, and that death occurred, on the date stated above, at 10 30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

Chronic Nephritis

131 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1290 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH No

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Electrocardiogram Clinical Laboratory

(Signed) Carl H Holz, M. D.

1/27, 1930 (Address) City Hospital

*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 U.	2-6 1930
20. UNDERTAKER	**ADDRESS**
Walter Richter	3500 Rutgers St

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.

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Brown