WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

14724

File No. 4128

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 701

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

City St. Louis, Mo. (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Frank Brown

(a) Residence. No. 915 N. Whittier 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 33 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	Col.	Wid.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt 1864 unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	66	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Porter
(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) Texas

PARENTS

10. NAME OF FATHER Efee Brown

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

12. MAIDEN NAME OF MOTHER Bettie Unknown

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

14. INFORMANT A. Gertrude Creath
(Address) City Hosp. #2

15. FILED [illegible] 19 [illegible] Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-13- 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-12- 1930, to 4-13- 1930 that I last saw him alive on 4-13- 1930 and that death occurred, on the date stated above, at 9 47 Am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C
(duration) 1 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? NO DATE OF .....
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. E. Hale, M. D.
4/14/1930 (Address) City Hosp. #2

*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
St. Peters Cem.	April 25 1930
20. UNDERTAKER	ADDRESS
W. C. Garden	2649 Morgan St.

7525