

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

Do not use this space.

2976

**1. PLACE OF DEATH**

County .....  
Township .....  
City ..... No. *419 Wash*

Registration District No. *791*  
Primary Registration District No. *1000*

File No. ....  
Registered No. *125* St. .... Ward)

**2. FULL NAME**

*Joe Brown*  
(a) Residence No. *419 Wash* St. *25* Ward. (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*

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *None*

7. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

8. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*abt 65* — — —

9. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. *Trameters*  
(b) General nature of industry, business, or establishment in which employed (or employer) *108*  
(c) Name of employer *P. J. Hammill Co.*

10. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo.*

11. NAME OF FATHER *Unknown*

12. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *" Unknown Mo.*

13. MAIDEN NAME OF MOTHER *" Unknown*

14. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *"*

15. INFORMANT *P. J. Hammill*  
(Address) *924 1/2 Main St*

FILED *JUN -5 1933* REGISTRAR *May - C. F. Anderson*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 31*

17. *No Physician in attendance*  
HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... *5 a*..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*108*  
*Pneumonia*  
*Labar*  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *108*  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH. DATE OF.....  
WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *J. W. Kerner, M.D.*  
*1/4 1933* (Address) *Dep. Coroner*

\*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  
*Calvary* *July 5 1933*

20. UNDERTAKER ADDRESS  
*Bussick-Pelhaus 1138 76*

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.

1866 (P. 1000)