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.

JUL 14 1936

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

Do not use this space.

24891

File No. 6547

Registered No.

1. PLACE OF DEATH

County

Township

City St. Louis (No. City Hospital No.1 St. Ward)

Registration District No. 791

Primary Registration District No. 1003

B. 4246 Jacqueline Brower

2. FULL NAME

(a) Residence, No. 1404 Madison St., 26 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: female

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) Nov 3 1935

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
0	7	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. nil

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

FATHER

13. NAME John Brower

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Josephine Zerjav

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wisconsin

17. INFORMANT (ADDRESS) Hosp. Info. M.H.Kent City Hospital No.1

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Charles Mo. DATE June 31 1936

19. UNDERTAKER (ADDRESS) Cunningham & Muchaney St. Charles, Mo

20. FILED JUN 29 1936 19 J F Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/28/36, 19

22. I HEREBY CERTIFY, That I attended, deceased from 6/23/36 19 to 6/28/36, 19

I last saw her alive on 6/28/36, 19 Death is said to have occurred on the date stated above, at 3/05 P m.

The principal cause of death and related causes of importance were as follows:

Broncho-pneumonia

Bacillary Dysentery

Date of onset

Other contributory causes of importance:

13b

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Geo Seibold, M. D.

(Address) City Hospital No.1