

JAN 10 1938

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

43514
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **City Hospital No. 1** Registered No. **11764**
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

Dorothy Brooks
(a) Residence, No. **St. City Hospital No. 1** (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 **M**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 1 1918.**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
19 7 19.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **Laundress**
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation **23 1/2**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

13. NAME **Oscar Brooks.**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio.**

15. MAIDEN NAME **Alice Cooper.**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio.**

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **Akron Ohio. Dec. 22, 1937**

19. FUNERAL DIRECTOR (ADDRESS) **J. J. Quinn.**

20. FILED **DEC 22 1937 1522 N Grand Bldg.**
J. Bredich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12/20/37** 19 **19**

22. I HEREBY CERTIFY, That I attended deceased from **12/12/37** to **12/20/37**, 19 **19**
I last saw her alive on **12/20/37**, 19 **19**. Death is said to have occurred on the date stated above, at **2.25 p.m.**

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

Septicemia - nasal & pharyngeal

Date of onset

Other contributory causes of importance: **10**

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) **H. A. Rawlinson**, M. D.
(Address) **City Hospital No. 1**

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGINAL RESERVE FOR BINDING
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.

V. S. 2. 50M-7-20-37
I X 12004

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 1391

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)