

REC'D JUN 12 1939

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

16728  
Do not use this space.791  
1008

Registered No. 4262

## 1. PLACE OF DEATH

- (a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City St. Louis..... (d) Street No. Firmin Deloge Hospital..... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(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.

## 2. PRINT FULL NAME

- (a) Residence, No. 650 Anna Jane Brown  
York Hotel 6 th. & Market St. St. 25  
(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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 25, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
74 5 12

- OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
9. Industry or business in which work was done, as 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) Rock Island Illinois

FATHER 13. NAME Patrick Carr

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

MOTHER 15. MAIDEN NAME Ann O'Rourke

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

17. INFORMANT Will A. Brown  
(ADDRESS) York Hotel 6th. & Market st.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Calvary Cem. DATE May 10 1939

19. FUNERAL DIRECTOR C. Hoffmeister U.&L.Co.  
(ADDRESS) 7814 S. Broadway

20. F MAY 8 1939  
J. B. [Signature] Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 7 1939

22. I HEREBY CERTIFY, That I attended deceased from MAY 6 1939, to May 7 1939

I last saw her alive on May 6 1939 Death is said to have occurred on the date stated above, at 4.15 a.m.  
The principal cause of death and related causes of importance were as follows:

Cerebral embolism  
auricular fibrillation ?  
arterio sclerotic heart disease ?  
Date of onset May 7

Other contributory causes of importance:

Name of operation..... Date of.....  
What test confirmed diagnosis? Chemical Was there an autopsy? yes

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? no  
If so, specify Tubercular M. D.  
(Signed) J. B. [Signature]  
(Address) 6402 Morganford

64025  
10-12-20  
Hoffmeister

STATEMENT BY LICENSED EMBALMER

I, Linus C. Hoffmeister, Licensed Embalmer No. 3871

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

**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.)**