DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 974

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 974

FILED FEB 17 1940

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4yrs. 10mo. 4days (Specify whether years, months or days)

In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")

(d) Street No. 119 S. Compton Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME HENRY BROWN 650

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race Colored

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug. 21, 1876 (Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days 24 If less than one day hr. min.

9. Birthplace (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation Freighter 1

11. Industry or business

FATHER
12. Name Albert Brown 1
13. Birthplace (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name Rose Tucker Mississippi
15. Birthplace (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant's own signature Peter Todd
(b) Address 5400 Arsenal St.

17. (a) (Burial, cremation, or removal) (b) Date thereof 1-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Richter
(b) Address 3500 Rutgers

19. (a) JAN 31 1940 (Date received local registrar) (b) J. F. Burdick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14 year 1940 hour 12:40 minute P. M.

21. I hereby certify that I attended the deceased from 7-1-39 7-1-39, 19__, to 1-14-40, 19__; that I last saw him alive on 1-14-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis with myocardial degeneration	
Due to 7-1-39x	
Due to Lobar -pneumonia organism unknown 1-6-39	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy No	

PHYSICIAN — Underline the cause to which death should be charged statistically.

100

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] M.D. (M. D. or other)
Address 5400 Arsenal Date signed 1-15-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.