

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community unknown

3. (a) PRINT FULL NAME Lee BROWN

8. (b) If veteran, name war World 8. (c) Social Security No. -

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Beulah Brown 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased April 13, 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>11</u>	<u>10</u>	hr. _____ min.

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

10. Usual occupation WPA laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Unavailable 9

13. Birthplace Unavailable
(City, town, or county) (State or foreign country)

14. Maiden name Unavailable

15. Birthplace Unavailable
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schellig

(b) Address Clinical Clerk, Vet. Adm. Bldg., Jeff. Bks., Mo.

17. (a) Removal (b) Date thereof 3-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Murphysboro, Illinois

18. (a) Signature of funeral director Chas. J. Stater

(b) Address 4107 Finney Ave. St. Louis, Mo.

19. (a) MAR 24 1940 (Date received local registration) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County _____

(c) City or town Murphysboro
(If outside city or town limits, write "RURAL")

(d) Street No. 608 North 17th Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23,
year 1940 hour 11:30 minute _____ A.M.

21. I hereby certify that I attended the deceased from March 18, 1940 to March 23, 1940;

that I last saw him alive on March 23, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Acute appendicitis with rupture and peritonitis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations See above

Of autopsy No

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? _____

While at work? C. W. Hughes (Specify type of place) Means of injury _____

23. Signature C. W. Hughes, M.D. (M. D. or other) _____

Address Ch. Med. Off., VAF, Jeff. Bks., Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

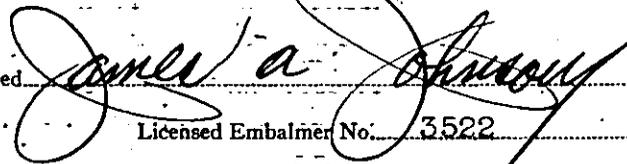
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

James A. Johnson

, Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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.