

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

10. 33
121432

MAY 15 1940

State File No. 3081
Registrar's No.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ida Brookshire 626

8. (b) If veteran, name war None

8. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife late Thomas Brookshire

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

7. Birth date of deceased Oct. 17 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>5</u>	<u>15</u>	hr. min.

9. Birthplace West Plains Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Beauty Operator

11. Industry or business retired 5 years

MOTHER FATHER { 12. Name Charles A. Delabar

13. Birthplace Alsace-Lorraine
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Martin

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

16. (a) Informant Robert Delabar

(b) Address 4452 Gibson Ave.

17. (a) Cremation (b) Date thereof 4-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory

18. (a) Signature of funeral director Kriegshauser Mortuary

(b) Address 4104 Manchester Ave.

19. (a) APR 3 1940 (b) J.F. Beckwith
(Date received local health officer's certificate)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

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

(d) Street No. 4452 Gibson Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st
year 1940 hour 3:45 minute P.M. M.

21. I hereby certify that I attended the deceased from Feb 23,
1940 to April 1, 1940;
that I last saw her alive on April 1, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Hemorrhage 12 days

Due to Peptic Ulcer 6 months

Due to _____

Other conditions hypertension 2 yrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Bleeding Peptic Ulcer

Duration
Underline the cause to which death should be charged statistically.

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? _____
(Specify type of place) (e) Means of injury _____

23. Signature J.P. Brennan, M.D.

Address 539 N Grand Date signed 4/3/40

Dr. J. Anthony Brennan
Humboldt Bldg. 1.30 to 4.30

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.....

Edwin A. Bernath

Licensed Embalmer No.

3084

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.