

Registration District No. 799

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. MARY HOSPITAL Infirmary
(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 MISSOURI, ANDERSON, BROWNER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife LELAND BROWNER 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased MAR 27 1896
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>5</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation DOMESTIC

11. Industry or business _____

MOTHER FATHER
12. Name WM. SMITH
13. Birthplace POTSDAM MO
14. Maiden name SARAH HOLLAND
15. Birthplace CHRISTIAN ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature S. Ral. Mayo
(b) Address #1212 Page Bl.

17. (a) _____ Date thereof SEPT 28-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM

18. (a) Signature of funeral director R. G. Walton
(b) Address 2707 Stoddard

19. (a) SEP 27 1940 (b) _____
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 8
(c) City or town ST. LOUIS 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4121^a PAGE BL
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 25
year 1940 hour 10:45 minutes 11 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to SEPT 27 1940, 19____
and that I last saw him/her alive on SEPT 24 1940, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Obstruction of Volvulus in Cecum
Due to Perforated Tubo-ovarian abscess
Due to non-malignant non-puerperal
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration 7 days
about 10 days

Major findings: Intestines twisted + knotted by adhesions
Of operations _____
Of autopsy similar above stated

PHYSICIAN _____
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) _____ (Manner of injury)
28. Signature S. Ral. Mayo (M. D. or other) _____
Address 2707 Stoddard Date signed SEP 27 1940

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.

WHILE FATHER USE ENTERING BLACK INK—MAKE A PERMANENT RECORD

1 X9511

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 William J. McRow

Licensed Embalmer No. 2174

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.