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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

33656

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 791

Primary Registration District No.

Registrar's No. 8352

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

### 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:  
1019 North Fourth St.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3  
(Specify whether)  
 In this community 3  
years, months or days

3. (a) PRINT FULL NAME Bert E. Brown

8. (b) If veteran, name war.....  
 8. (c) Social Security No. 489-07-2832

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

6. (b) Name of husband or wife Ada  
 6. (c) Age of husband or wife if alive 58 62 years

7. Birth date of deceased October 31 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>11</u>	<u>16</u>	hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business 9

12. Name Herbert Brown

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

14. Maiden name unknown

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

16. (a) Informant Ada Brown

(b) Address Ad 4779 Milentz

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof Oct. 9, 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill

18. (a) Signature of funeral director John J. Ziegenhein

(b) Address 7027 Gravois Ave.

19. (a) OCT 8 1940  
(Date received local registrar) (b) [Signature]

### 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4779 Milentz  
(If rural, give location)  
 (e) [Signature] Physician years.

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7  
 year 1940 hour 2 minutes 20 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death  
Coronary Occlusion  
Atherosclerotic Coronaries

Due to.....

Due to.....

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....

Of autopsy.....

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? 5  
(Specify type of place) (a) Periods of injury

23. Signature [Signature] (M. D. or other)

Address [Signature] Date signed 10/8/40

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.