

FILED NOV 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36332

State File No. _____

Registration District No. 7824

Primary Registration District No. 200

Registrar's No. 1879

1. PLACE OF DEATH:

(a) County. St. Louis
(b) City or town. Grandelith-Herbert
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 572 days
(Specify whether
In this community. 4 yrs
years, months or days)

3. (a) PRINT FULL NAME. TRUEINE BROOKES

3. (b) If veteran, _____ 3. (c) Social Security
name war. _____ No. None

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife. Darwin Robert Brookes 6. (c) Age of husband or wife if
alive. 37 years
7. Birth date of deceased. Oct. 4 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 11 29 hr. _____ min.

9. Birthplace. CORPUS CHRISTI TEXAS
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK

11. Industry or business HOME

MOTHER FATHER { 12. Name. A. A. CAMPBELL 2
13. Birthplace. NEW YORK
(City, town, or county) (State or foreign country)
14. Maiden name. CATHERINE CAMPBELL
15. Birthplace. CANADA
(City, town, or county) (State or foreign country)

16. (a) Informant Koch Hosp. Records

(b) Address Koch Hosp. Koch mo.

17. (a) Cremation (b) Date thereof 10/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MISSOURI STATE CEMETERY

18. (a) Signature of funeral director. C. Hoffmeister, M.D.

(b) Address 7814 S. Broadway, St. Louis Mo.

19. (a) OCT - 5 1940 (b) DR. M. J. M. M. M. M.
(Date received local registrar) (Registrar's 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. 2355 Albion Place
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3
year 1940 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from 2-1-1899 to 10-3-1940
that I last saw her alive on 10-3-1940
and that death occurred on the date and hour stated above.

Immediate cause of death. Pulmonary Tuberculosis Duration 10 yrs.

Due to _____

Due to 23

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

Major findings: _____
Of operations _____

Of autopsy. Pulmonary Tuberculosis

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)
(e) Means of injury _____

23. Signature B. Friedman (M. D. or other) M.D.

Address Koch Hosp. Koch mo. Date signed 10-3-40

(Licensed Embalmer's Statement on Reverse Side)

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

132 3 0 1945

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 H. Leisinger

Licensed Embalmer No. 4049

P. O. Address 6464 Chippewa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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