

Registration District No. **784**

Primary Registration District No. **222**

Registrar's No. **1885**

1. PLACE OF DEATH:

(a) County **St. Louis County**
(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 **since August 19/40**
(Specify whether
In this community **Same**
years, months or days)

3. (a) PRINT FULL NAME **BROWN, Cleo C.**

8. (b) If veteran, name war **World, 1918** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Pearl Brown** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **September 5 1893**
(Month) (Day) (Year)

8. AGE: Years **47** Months **14** Days **1** If less than one day hr. min.

9. Birthplace **Dallas City** **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cement Worker**

11. Industry or business **Unknown**

12. Name **William Brown**

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

14. Maiden name **Cordelia Livingston**

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

16. (a) Informant **Mr. Schilling**
(b) Address **Government Records, VAP, Jeff. Bk., Mo.**

17. (a) **REMOVAL** (b) Date thereof **10-9-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DALLAS CITY, TX.**

18. (a) Signature of funeral director **C. W. Hughes**

(b) Address **2814 S. 13th**

19. (a) **OCT - 6 1940** (b) **R. M. Hughes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County
(c) City or town **Dallas City**
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **6**
year **1940** hour **7:35A.M.** minute M.

21. I hereby certify that I attended the deceased from **8/19/40** to **10/6/40**

that I last saw him alive on **10/6/40** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis, active, far advanced**
and

Due to **tuberculous pharyngitis**

Due to

Other conditions **23**
(Include pregnancy within 3 months of death)

Major findings: **No operation**

Of operations

Of autopsy **No-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? **Chief Medical Officer** of injury

23. Signature **C. W. HUGHES, M.D.** (M. D. or other)

Address **Chief Medical Officer.** Date signed

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

Linus C. Hoffmeister

Licensed Embalmer No.

3871

P.O. Address

7814 S. Broadway

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.