

FILED MAY 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **12720**

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **3150**

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:
124 E. Stein st.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **Life**
years, months or days

3. (a) PRINT FULL NAME **John F. Brown Sr.**

8. (b) If veteran, name war **None** 8. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 23 1865**
(Month) (Day) (Year)

8. AGE: Years **75** Months **8** Days **15** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business **Retired**

12. Name **John F. Brown**

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

14. Maiden name **Hanna**

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

16. (a) Informant **Mrs. Fred W Jaedel**

(b) Address **124 E. Stein st.**

17. (a) **Burial** (b) Date thereof **April 8, 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive Cemetery**

18. (a) Signature of funeral director **C. H. ...**

(b) Address **7814 S. Broadway**

19. (a) **APR 11 1941** (b) **J. B. ...**
(Date received local health officer's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000 171**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **124 E. Stein st.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **8**
 year **1941** hour **9** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **3/31/41**
 19____ to **4/8** 19____
 that I last saw him alive on **4/7/41** 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** **3 yrs.**

Due to **Senility**

Due to _____

Other conditions **19**
(Include pregnancy within 3 months of death)

Major findings: Of operations **ASC**
 Of autopsy **19**

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 **0**

23. Signature **Durant Benjamin** (M. D. or other) **MD**
 Address **7408 Michigan** Date signed **4/8/41**

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

MOTHER FATHER

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

bill over for
Wed a.m.

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 Linn 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.