

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 1411 A Bessies St
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

8. (a) PRINT FULL NAME Joe Anna Brown
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F.M. 3 5. Color or race col. 6. (a) Single, widowed, married, divorced Child

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

7. Birth date of deceased June 3 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 30 - 7 min.

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

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER { 12. Name William H. Brown
13. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)
14. Maiden name Milburn Anderson
15. Birthplace Newman I. S. A.
(City, town, or county) (State or foreign country)

16. (a) Informant Milburn Brown
(b) Address 1411 A Bessies St

17. (a) Burial (b) Date thereof 6 3 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. J. Burles
(b) Address 1419 6 3rd

19. (a) JUN 9 - 1941 (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 1721
(If outside city or town limits write "RURAL")
(d) Street No. 3411 Glasgow
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day June
year 1941 hour _____ minute 60 M.

21. I hereby certify that I attended the deceased from June 2 1941 to June 2 1941; that I last saw her alive on June 3 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Strep

Due to 159

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. J. Burles (M. D. or other) _____
Address 2742 - Fremont Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

.....
working under my personal supervision.



Registered Apprentice No.....

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.