

Registration District No. 377

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution:
Mount St. Rose Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 hours**
In this community **16 YRS**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis UNIVERSITY CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **6643 Chamberlain** 96
(If rural, give location)
(e) Citizen of foreign country? **=** (Yes or No) 3
If yes, name country **=** 1 3

3. (a) PRINT FULL NAME **BROOKS, OWEN**

3. (b) If veteran, name war **No** 3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **FANNY BROOKS** 6. (c) Age of husband or wife if alive **51** years
7. Birth date of deceased **JULY-25-1888**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54: 9 24 hr. min.

9. Birthplace **SHILBYVILLE CO TENNESSEE**
(City, town, or county) (State or foreign country)

10. Usual occupation **MACHINE OPERATOR**

11. Industry or business **MEG. CO.**

MOTHER FATHER { 12. Name **LYNCH BROOKS**
13. Birthplace **UNKNOWN TENNESSEE**
(City, town, or county) (State or foreign country)
14. Maiden name **ROTH REEVES**
15. Birthplace **UNKNOWN TENNESSEE**
(City, town, or county) (State or foreign country)

16. (a) Informant **Owen a Brooks**

(b) Address **6643 CHAMBERLIN AVE**

17. (a) **BURIAL** (b) Date thereof **MAY-22-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAKHILL CEMETERY**

18. (a) Signature of funeral director **Parker and Co**

(b) Address **WEBSTER GROVES MO.**

19. (a) **MAY 21 1943** (b) **J. M. Quinn**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19**
year **1943** hour **7** minute **45** P. M.

21. I hereby certify that I attended the deceased from **5/19**
1943, to **5/19** 1943;
that I last saw him alive on **5/19** 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary abscess + embolism** Duration **2 mo.**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **114 d** PHYSICIAN _____
Of autopsy **same** 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 **John B. Murphy** (M. D. or other) **M.D.**
Address **201 S. Broadway** Date signed **5/19/43**

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

16
0
0

JUN 11 1948

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 Parker and Co

Licensed Embalmer No. 1332

P. O. Address Webster Groves Mo

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, fact should be so stated above.