

FILED OCT 13 1943 318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **8584**

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Hrs. 55 Min.**
(Specify whether _____)
In this community _____
years, months or days)

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. **2920 Chouteau Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Leo Christian Brooks**

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

4. Sex **Male** 5. Color or **late Negro** 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased **8 28 43**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **5 hr. 55 min.**

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **Edward Brooks**

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

14. Maiden name **Viola Raymond**

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

16. (a) Informant **E. M. Sheard**

(b) Address **2601 N. Whittier Street**

17. (a) **Burial** (b) Date thereof **SEP 30 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **L. H. Hensch**

(b) Address **2601 N. Whittier Street**

19. (a) **SEP 29 1943** (b) **J. F. Brodeur**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **29**
year **43** hour **2** minute **50** am.

21. I hereby certify that I attended the deceased from **8 - 28**, 19**43** to **8 - 29**, 19**43**
that I last saw him alive on **8 - 29**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxia Neonatorum**

Due to **Unknown**

Due to **Unknown**

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

Major findings: Of operations **FD**

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. Smiley** (M. D. or other) _____

Address **2601 N. Whittier St.** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

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, fact should be so stated above.