

FILED DEC 22 1943 **818**  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **10862**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town **St. Louis, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**2908 Laclede Ave. /**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

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. **2908 Laclede Ave.**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Theresa Brown**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female**

5. Color or Race **Col.**

6. (a) Single, widowed, married, divorced **9**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **4 20 1904**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>39</b>	<b>7</b>	<b>16</b>	_____ hr. _____ min.

9. Birthplace **Maunie, Ill.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Maid**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Rufus Keene**

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

14. Maiden name **Washa Keene**

15. Birthplace **Union County, Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Dosha Keene**

(b) Address **3438 Lucas Ave.**

17. (a) **Burial** (b) Date thereof **12-13, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **Quintie L. Toney**

(b) Address **3129 Lucas Ave.**

19. (a) **DEC 9 1943** (b) **J. J. Pudech**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **6**  
year **1943** hour **5 A.M.** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **Dec 1**  
**1943** to **Dec 6**, 19**43**

that I last saw her alive on **Dec 5**, 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Acute Congestive Failure**  
(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations \_\_\_\_\_

Of autopsy **none**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

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 **A. S. Vaughn** (M. D. or other) \_\_\_\_\_  
Address **117 Jefferson** Date signed **Dec 8**

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, *me*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Clark Young*

Licensed Embalmer No. ....

*3371*

P. O. Address.....

*St Louis*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

*Jan*

Registration District No.

*318*

Primary Registration District No.

*1003*

Registrar's No.

*10862*

1. PLACE OF DEATH:

(a) County *St. Louis*  
(b) City or town *St. Louis*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME *Theresa Brown*

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

4. Sex *F* 5. Color or race *C* 6. (a) Single, widowed, married, divorced *Widow*

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

7. Birth date of deceased *April 20 1903*  
(Month) (Day) (Year)

8. AGE: Years *39* Months *7* Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) *DEC 27 1943* (b) *J. J. Budeck*  
(Date received local burial or cremation) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* Day *27* Year *1943* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-39582