

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 18 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43641

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 2791

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6747 Vernon
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth Brinson
3. (b) If veteran, name war -- 3. (c) Social Security No. --

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 14 day 15 December
year 1943 hour 4:15 minute P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Wid.
6. (b) Name of husband or wife Harry Brinson (Dec.) 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2-11-1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-6-43 19. to 12-14-43 19. ;
that I last saw her alive on 12-14-43 19. ;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>10</u>	<u>3</u>	_____ hr. _____ min.

Immediate cause of death Intra-cranial hemorrhage Duration 7 days
Due to hypertension unknown
Due to _____

9. Birthplace Keokuk Iowa
(City, town, or county) (State or foreign country)

Other conditions Renal colic
(Include pregnancy within 3 months of death)

10. Usual occupation Switch Board Operator
11. Industry or business University City Hall

Major findings: Of operations S3a1
Of autopsy Intra-cranial hemorrhage possible Meningeal
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name John Timlan
13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth O'Keefe
15. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant S.P.C. Hunsicker
(b) Address Clayton, Mo.
17. (a) BURIAL (b) Date thereon Dec 17-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Subermy Cemetery
18. (a) Signature of funeral director A. Malvern Smith
(b) Address 516 S. Delmar St. Bl.
19. (a) DEC 16 1943 (b) E.D. McSweeney, M.D.
(Date received local registrar) (Registrar's signature)

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 Neederhiser (M. D. or other) M.D.
Address St. Louis County Hospital Date signed 12-18-43

DEC 2 9 1960

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..... *H. G. Farris*

Licensed Embalmer No. *3384*

P. O. Address..... *St. Louis, 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.