

FILED FEB 27 1944

State File No. ....

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 297

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

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: St. Ann's Hospital - 5301 Page  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
176

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. St. Ann's Hospital - 5301 Page  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Joseph Brown

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10  
year 1944 hour 10 minute A M.

21. I hereby certify that I attended the deceased from 1/8/44  
19..... to 1/10/44 19.....  
that I last saw him alive on..... 19.....  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced. 0

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

7. Birth date of deceased January 8 1944  
(Month) (Day) (Year)

Immediate cause of death.....  
Pneumonia

Due to.....

Due to.....

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

Duration

8. AGE: Years Months Days If less than one day

2 hr. min.

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

10. Usual occupation Infant

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name Irene Brown

15. Birthplace Perryville Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations.....

Of autopsy.....

16. (a) Informant St. Ann's Hospital  
(b) Address 5301 Page

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) Manner of injury.....

23. Signature J. J. Buech (M. D. or other).....  
Address 1467 Date signed.....

17. (a) Burial (b) Date thereof 1-11-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Walter Walters  
(b) Address 5301 Page Blvd.

19. (a) JAN 11 1944 (b) J. J. Buech  
(Date received from registrar) (Registrar's signature)

**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 *Walter Walters*

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.**