

FILED APR 1 1944
818

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8759
Registrar's No. 2927

Registration District No. 818

Primary Registration District No. 100

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 11 Hrs. 20 Mins.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 1033 N. Compton Ave. 21
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 1

3. (a) PRINT FULL NAME Ann Lee Brooks

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

4. Sex Female 5. Color or race Negro 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 10 31 43
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 11 hr. 20 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Wendell Brooks

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

14. Maiden name Annie Majors

15. Birthplace Durant Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Cather M. Shepard R.R. 2.

(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof 3-30-44
(Burial, cremation, or removal) (City or town) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director H. Merschman

(b) Address City Health Dept

19. (a) 3-29-44 (b) J. J. Brudack
(Date received local for registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 31
year 43 hour 5 minute 50 pm.

21. I hereby certify that I attended the deceased from 10 - 31, 1943, to 10 - 31, 1943
and that death occurred on the date and hour stated above.
that I last saw her alive on 10 - 31, 1943.

Immediate cause of death Prematurity Duration _____

Due to Unknown

Due to Unknown

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

Major findings: 157
Of operations _____

Of autopsy _____

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 H. D. Anshler (M.D. or other) _____

Address 2601 N. Whittier St. Date signed 2-23-44

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

MOTHER FATHER

844

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.