

FILED MAY 15 1944 18

1003

Registration District No. Primary Registration District No.

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

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: Missouri Baptist Hosp
(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 John M. Brown

3. (b) If veteran, name war none

3. (c) Social Security No. None

4. Sex Male

5. Color or Race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Carrie Brown

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Sept 21 1967
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 11
If less than one day
hr. min.

9. Birthplace Mt. Pisgah, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Samuel Brown

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

14. Maiden name Amanda DuBois

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

16. (a) Informant Carrie Brown

(b) Address Vienna, Ill.

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof May 5 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Vienna, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 3 1944 (Date received local registrar)

(b) J. F. Busch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Johnson

(c) City or town Vienna
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd
year 1944 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from Apr 17, 1944, to May 2, 1944,
that I last saw him alive on May 2nd, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Redemay Lung

Due to uraemia

Due to Nephrosis from Chr Nephrosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Resident hypertensive
Of operations crustal Apr 21, 44

Of autopsy 13/1

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?
..... (Specify type of place)

While at work..... (e) Means of injury.....

23. Signature Cl Brown (M. D. or other)

Address 958 Broadway Date signed 5/3/44

Duration

2 days

5 days

7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *John Agonowski*
Licensed Embalmer No. *3398*

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.