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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JUL 15 1944

Registration District No. 378 Primary Registration District No. 1003

State File No. 19523

Registrar's No. 5996

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

(d) Length of stay: In hospital or institution 0 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 6

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

(d) Street No. St. Ann's Hospital 100
(If rural, give location)
5301 Page Blvd. 17

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country 0

3. (a) PRINT FULL NAME Thomas Andrew Brown

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 0 M

5. Color or race W

6. (a) Single, widowed, married, divorced 0 Infant

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) I (Day) 1944 (Year)

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation — —

11. Industry or business — —

FATHER
12. Name x
13. Birthplace x (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Mary Elizabeth Brown
15. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant St. Ann's Hospital

(b) Address 5301 Page Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-44 (Month) (Day) (Year)

(c) Place: burial or cremation Calvery Cemetery

18. (a) Signature of funeral director Walter Walters

(b) Address 5301 Page Blvd.

19. (a) JUL 5 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day fourth year 1944 hour 4:30 minute A M.

21. I hereby certify that I attended the deceased from July first, 1944, to July 4, 1944 that I last saw him alive on July 3, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Extra dural Hemorrhages	3 days
Due to:	
Due to: Hemorrhagic Disease of Hem Born	2 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 161

Of autopsy Yes

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 14 S. Thomas Date signed 7/5/44

(Licensed Embalmer's Statement on Reverse Side)

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.