

FILED AUG 8 1944 318

State File No. _____

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. _____

6657
898
17
922

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:
Homer GPhillips
(If not in hospital or institution, write street number or location)
8 days
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 41 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1904a Papin
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John H Brooks

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 15 1873
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 26 If less than one day _____ hr. _____ min

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

10. Usual occupation Porter

11. Industry or business _____

MOTHER FATHER
12. Name Tom Brooks
13. Birthplace Miss /
(City, town, or county) (State or foreign country)
14. Maiden name Luvia (Unknown)
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant S T Coleman

(b) Address Homer G Phillips Hospital

17. (a) Autopsy (b) Date thereof 7-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washing St

18. (a) Signature of funeral director W. K. Rutger
(b) Address 2509 Rutger

19. (a) JUL 30 1944 (Registrar's signature) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1944 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 3, 1944 to July 11, 1944
that I last saw him alive on July 11, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhagen

Duration Unk

Due to _____

Due to _____

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

Major findings: 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? _____

(e) Means of injury _____

23. Signature Alva Moore (M. D. or other) _____

Address 2601 N Whittier St Date signed 7/13/44

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

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.