V. S. No. 2
00M—5-43
Rev. 5-17-39
Form I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22859

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6854

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:
Masonic Home Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 yrs (Specify whether years, months or days)
In this community 10 yrs.

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Mo (b) County Jackson

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME Mrs. Mable Brown.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 17 (Day) 1870 (Year)

8. AGE: Years 74 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business None

FATHER
12. Name Henry Blake
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Masonic Home Records
(b) Address St Louis Mo

17. (a) Burial Removal (Burial, cremation, or removal) (b) Date thereof 8-6-44 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director Bensieck - Richmond
(b) Address 4431 No Union

19. (a) AUG 5 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th
year 1944 hour 5:45 P.M. minute M.

21. I hereby certify that I attended the deceased from Feb. 1933.
, 19 , to August 4th , 1944;
that I last saw her alive on August 4th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertension	3 years
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature Glen Cameron (M. D. or other)
Address 508 N. Grand Blvd Date signed

(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. Howard P. Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis Mo

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.