

S. No. 2
M-843
7-5-17-39
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29409
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22862**
6566
Registrar's No.

FILED AUG 8 1944 318

Registration District No. **1003**
Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial 1117 Wright St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
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") 26
(d) Street No. 1117 Wright St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Browning
3. (b) If veteran, name war ? 3. (c) Social Security No. ?

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife minnie 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased May 11th 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 17
If less than one day _____ hr. _____ min.

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

10. Usual occupation O.A.A.

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel
13. Birthplace ?
(City, town, or county) (State or foreign country)

{ 14. Maiden name Mary Hanna
15. Birthplace ?
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address 4000 Hartford St.

17. (a) Burial (b) Date thereof 7 27 44
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cemetery

18. (a) Signature of funeral director W. J. White
(b) Address City Hospital, NO. 1

19. (a) JUL 26 1944 (b) J. P. Braseck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th
year 1944 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 27th
1944 to June 28th, 1944
that I last saw him alive on June 28th, 1944
and that death occurred on the date and hour stated above

Immediate cause of death Intestinal Obstruction
Strangulated
Inguinal Hernia
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: 1720
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 J. P. Braseck (M. D. or other) _____
Address 1515 Lafayette Date signed 8/29/44

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.