

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **2077**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Manchester
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Manchester Nursing Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 years 4
 (Specify whether
 In this community 2 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Charles 9
 (c) City or town St. Charles
 (If outside city or town limits, write "RURAL")
 (d) Street No. 30 River Drive
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country 1

3. (a) PRINT FULL NAME John B. Brown
 3. (b) If veteran, name war none 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 9
 year 1944 hour 8 minute 30 A M.

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
 6. (b) Name of husband or wife Sarah Brown 6. (c) Age of husband or wife if alive 1851 years
 7. Birth date of deceased Nov. 11 1851
 (Month) 11 (Day) 28 (Year)

21. I hereby certify that I attended the deceased from Sept 1, 1944 to Oct 9, 1944;
 that I last saw him alive on Oct 8, 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years 92 Months 10 Days 28 If less than one day hr. min.

Immediate cause of death chronic myocarditis Duration

9. Birthplace Ohio 1 (City, town, or county) (State or foreign country)

Due to generalized arteriosclerosis
 Due to A.B.D.

10. Usual occupation Retired farmer

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business Own farm

Major findings:
 Of operations
 Of autopsy
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Ireland 4 (City, town, or county) (State or foreign country)
 14. Maiden name Eliza White
 15. Birthplace Ireland 4 (City, town, or county) (State or foreign country)

16. (a) Informant George Brown
 (b) Address Box 223 St. Charles, Mo.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence

17. (a) (Burial, cremation, or removal) (b) Date thereof Oct. 10-1944
 (Month) (Day) (Year)

(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?

(c) Place: burial or cremation Oak Grove Cem. St. Charles, Mo.

(Specify type of place)
 While at work? (e) Means of injury

18. (c) Signature of funeral director Schader Funeral Home
 (b) Address Ballwin, Mo.
 19. (a) OCT 13 1944 (b) E. S. Mahan M.D.
 (Date received by registrar) (Registrar's signature)

23. Signature A. L. Merkle (M. D. or R. N.)
 Address 3507 Poloma Date signed 10-10-44

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

9600

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 Theo. Schrader

Licensed Embalmer No. 3066

P.O. Address Baltimore, Md.

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.