

S. No. 2
 OM-5-43
 v. 5-17-39
 X36671

4033

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 16 1945
 318

1003

1057

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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:
City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1/2 hour
 In this community Life
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED: 000
 (a) State Missouri (b) County 17
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL") 293
 (d) Street No. 1721 South 11th, St.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country M

3. (a) PRINT FULL NAME Gary Brooks
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Nov 15 1942
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 2 16 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Ernest Brooks

13. Birthplace Melbourne Ark.
 (City, town, or county) (State or foreign country)

14. Maiden name Goldie Brown

15. Birthplace Elvins Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Ernest Brooks

(b) Address 1721 South 11th, St.

17. (a) Burial (b) Date thereof: 2/3/45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) FEB 2 1945 (b) F. H. Predeck
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
 year 45 hour 2 minute 30-A-M.
 21. I hereby certify that I attended the deceased from January 23
1945 to Jan 31, 1945
 that I last saw him alive on Jan 31, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Scarlet Fever
Lobar Pneumonia

Duration
10 days
1 day

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) No

(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 Leroy E. Ellison (M.D. or other) MD

Address 3610 1/2 S Broadway Date signed 2-2-45

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No. 3633

P. O. Address. 2301 Lafayette

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. }