

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 28 1945

2487

Registration District No. **318** Primary Registration District No. **100** Registrar's No. _____

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 mo. 13 days**
(Specify whether _____)

In this community **20 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **261 St. Louis,**
(If outside city or town limits, write "RURAL") **121**

(d) Street No. **2616 Lawton**
(If rural, give location) **7**

(e) Citizen of foreign country? **0** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Harry Brown**

3. (b) If veteran, name war **Worlds war I** 3. (c) Social Security No. **561-16-9090**

4. Sex **Male** 5. Color or race **Col**

6. (a) Single, widowed, married, divorced **Unknown**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14,**
year **1945** hour **4** minute **15A.** M.

21. I hereby certify that I attended the deceased from **February 1,** 1945, to **March 14,** 1945;
that I last saw h. **im** alive on **March 14,** 1945;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

about 55 _____ hr. _____ min.

Immediate cause of death **Carcinoma of stomach with metas-**
tasas

Due to _____

Due to _____

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

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

10. Usual occupation **Sheff Cook**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Maie Agee**

(b) Address **2616 Lawton Blvd**

17. (a) **Burial** (b) Date thereof **Mar 19-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cem**

18. (a) Signature of funeral director **J. W. Hughes**

(b) Address **2620 Lawton Blvd**

19. (a) **MAR 18 1945** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy _____

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 **B. F. Murphy** (M. D.) _____

Address **Boonville** Date signed **3/16/45**

Duration **Unk.**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

100
17
9

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 *Clark Young*

Licensed Embalmer No. *3371*

P. O. Address *St. Louis*

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.