

FILED DEC 17 1946

Registration District No. **37**

Primary Registration District No. **30 1/2 3**

Registrar's No. **3475**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days
(Specify whether years, months or days)

In this community 2 1/2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town So. Kinloch
(If outside city or town limits, write "RURAL")

(d) Street No. 35 Richards
(If rural, give location)

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

3. (a) PRINT FULL NAME Jacob Brown

3. (b) If veteran, name war _____

3. (c) Social Security No. 49a-01-4804

4. Sex M 5. Color or race C

6. (b) Name of husband or wife ANNIE HOWARD CLEMENS

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased August 27 1895
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation Porter

11. Industry or business _____

MOTHER FATHER

12. Name DONALD BROWN

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

14. Maiden name FRANCES

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

16. (a) Informant ANNIE BROWN

(b) Address 35 Richards - So. Kinloch

17. (a) Burial (b) Date thereof Dec 12 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Boyd Brob

(b) Address So. Kinloch, Mo

19. (a) 12-10-46 (b) Ruth Clemens
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5 year 1946 hour 9 minute 15 p.M.

21. I hereby certify that I attended the deceased from November 11, 1946, to December 5, 1946; that I last saw him alive on December 5, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial insufficiency

Due to Hypertensive cardiac vascular disease

Due to anemia 93d

Other conditions anemia 93d
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____

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) Means of injury _____

23. Signature John Hofer MD (M. D. or other) _____
Address _____ Date signed _____

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

JAN 9 1947

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 *Lawrence E. Woodman*

Licensed Embalmer No. *434X*

P. O. Address *2 Harris*

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.