

No. 2
-12-45
-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42190

FILED DEC 23 1946 318

State File No. _____
Registrar's No. 421304

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(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 17 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Alexander Brooks

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 2 | 5. Color or race col | 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary | 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Jan 14th 1884
(Month) (Day) (Year)

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

62	11	1	_____ hr. _____ min.
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9. Birthplace Monticello Ark
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business _____

12. Name Y.B. Brooks

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

14. Maiden name Mary Smith

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

16. (a) Informant Lois Moore

(b) Address 4643a Page Avenue

17. (a) removal (b) Date thereof 12-19-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shady Grove cemetery Monticello Ark

18. (a) Signature of funeral director J. H. Handle & Son

(b) Address 3133 Bell Avenue

19. (a) DEC 17 1946 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County osceola

(c) City or town St. Louis 11/17
(If outside city or town limits, write "RURAL.")

(d) Street No. 4643 a Page 9
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15
year 1946 hour 4 minute 40 A. M.

21. I hereby certify that I attended the deceased from Nov. 28 1946 to Dec. 15 1946
that I last saw him alive on Dec. 15, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Hypertensive Cardiovascular Disease Undet.
Acidosis; Arteriolar Nephrosclerosis

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 12/1
Of autopsy No

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? _____

(Specify type of place) _____
While at _____ (e) Means of injury 1

23. Signature E. B. Williams (M. D. or other) _____

Address 2601 N Whittier Date signed 12/16/46

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

41000

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 J. J. Watson
Licensed Embalmer No. 2698
P. O. Address 2769 Chouteau

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.