

No. 2  
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-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 31 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10610

State File No. ....

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2903**

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: Homer G. Phillips Hospital **0**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 1/2 hrs.  
(Specify whether years, months or days)

In this community 25 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis **600**  
**2117**

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

(d) Street No. 2301 O'Fallon **9**  
(If rural, give location) **0**

(e) Citizen of foreign country? None (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Sarah Brown

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13,  
year 1947 hour I minute 45 P.M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;

that I last saw h..... alive on ....., 19.....;

and that death occurred on the date and hour stated above.

4. Sex Female 75. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leonard Brown

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

7. Birth date of deceased: Jan. 18, 1908  
(Month) (Day) (Year)

Immediate cause of death .....

Meningitis (Dip. Antibiotics)

Due to .....

Due to 8/0

Other conditions (include pregnancy within 3 months of death) .....

8. AGE:

Years	Months	Days	If less than one day
<u>39</u>	<u>I</u>	<u>25</u>	hr. min.

Major findings:  
Of operations .....

Of autopsy .....

PHYSICIAN .....

Underline the cause to which death should be charged statistically.

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

10. Usual occupation housemaid

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? .....

11. Industry or business In Private Families

MOTHER FATHER {

12. Name James Cooper

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

14. Maiden name Mary Dimery

15. Birthplace E. St. Louis, Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Cooper

(b) Address 2306 Oak St.

17. (a) Removal (b) Date thereof March 19, '47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation El St. Louis Ill.

23. Signature Patrick E Taylor (M. D. or other) **5**  
Address 1300 Clark St Date signed .....

While at work? (Specify type of place) .....

(c) Means of injury .....

18. (a) Signature of funeral director C. J. Nash

(b) Address 3847 Page Blvd

19. (a) MAR 18 1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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.....

*Charles Downing King* ..... , Registered Apprentice No. *475*  
working under my personal supervision.

Signed *C. J. Spink* .....  
Licensed Embalmer No. *2432*  
P. O. Address *3847 Page Blvd*

**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.**