S. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 35545
9370

Registration District No. 318 Primary Registration District No. 1003 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: St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 2025 Obear Ave 9
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME FRANK BROWN

3. (b) If veteran, name war NO

3. (c) Social Security No. 488-03-8284

4. Sex MALE

5. Color or race W

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

6. (b) Name of husband or wife LILLIE BROWN

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 3 (Month) 28 (Day) 1879 (Year)

8. AGE: Years 68 Months 6 Days 10 If less than one day hr. min.

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

10. Usual occupation ASSEMBLY MAN

11. Industry or business WELSH BABY CARRIAGE Co

FATHER
12. Name RUPHUS
13. Birthplace (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name JENNIE PARCEL
15. Birthplace (City, town, or county) OHIO (State or foreign country)

16. (a) Informant MURRAY BORWIN
(b) Address 2025 Obear Ave

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/11/47 (Month) (Day) (Year)
(c) Place: burial or cremation LAKEWOOD PARK

18. (a) Signature of funeral director [signature]
(b) Address 2117 E. Grand

19. (a) OCT 10 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8th year 1947 hour 6:10 minute P M.

21. I hereby certify that I attended the deceased from 10-2-47, 19, to 10-8-47, 19; that I last saw him alive on 10-8-47, 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Lung Abscess-Non Tuberculous Cause not determined | 24 Nos |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN

Underline the cause of 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 work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 1515 Lafayette Date signed 10-9-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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. Frank A Moore

Licensed Embalmer No. 3104

P. O. Address.....

**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.**