. S. No. 2
M—1/47
ev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 9 1947

Registration District No. 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 40486

Registrar's No. 2507

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

96
0
0

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Wilston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6228 Wells Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 32 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State State (b) County St. Louis 96
(c) City or town Wilston 0
(If outside city or town limits, write "RURAL")
(d) Street No. 6228 Wells Avenue 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Zerbie T. Brown
3. (b) If veteran, name war
3. (c) Social Security No. 708-16-9411

4. Sex Male 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Medacina Brown
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased December (Month) 7 (Day) 1885 (Year)

8. AGE:

Years	Months	Days	If less than one day
61	11	21	hr. min.

9. Birthplace Martinsburg, Missouri 0
(City, town, or county) (State or foreign country)
10. Usual occupation Electrician
11. Industry or business Pullman Co.
FATHER
12. Name John Brown 0
13. Birthplace Unknown, Missouri
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Malissa Martin
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
16. (a) Informant Medacina Brown
(b) Address 6228 Wells Avenue
17. (a) Burial (b) Date thereof 12/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Avenue
19. (a) 12-4-47 (b) Beula Shay MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28
year 1947 hour 9 minute A. M.
21. I hereby certify that I attended the deceased from 11/24/47, 19..., to 11/28/47, 19...;
that I last saw h..... alive on ....., 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Nephritis	2 Mos.
Due to Rheumatic Fever	3 Das.
Due to 58	
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 0
23. Signature X Rolla Bracy (M. D. or other) ✓
Address 6400 Easton Avenue Date signed 12/2/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

JUL 14 1948

DEC 9 1948

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 John K. Cunningham Registered Apprentice No. 452 working under my personal supervision.

Signed

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.