

17-39

FILED FEB 9 1948
Registration District No. **367**

Primary Registration District No. **3063**

Registrar's No. **187**

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 **18 DAYS**
(Specify whether)

In this community **1 YEAR**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS 96**

(c) City or town **NORMANDY**
(If outside city or town limits, write "RURAL")

(d) Street No. **7012 LEXINGTON**
(If rural, give location)

(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **William Frank Brown**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **NONE**

4. Sex **M** race **W**

5. Color or divorced **M**

6. (b) Name of husband or wife **EFFIE**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **11 1 1893**
(Month) (Day) (Year)

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

64 2 20 hr. min.

9. Birthplace **REYNOLDS CO. MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business **NONE**

12. Name **GEORGE BROWN**

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

14. Maiden name **ELVERA LUMBEL**

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

16. (a) Informant **EFFIE BROWN**

(b) Address **7012 LEXINGTON**

17. (a) **BURIAL** (b) Date thereof **1-23-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **IRONTON, MO**

18. (a) Signature of funeral director **ALBERT H. HOPPE**

(b) Address **4700 WASHINGTON BLVD**

19. (a) **1-22-48** (b) **George Hoppe MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY** day **21**
year **1948** hour **2** minute **45** A.M.

21. I hereby certify that I attended the deceased from **Jan 3 1948** to **Jan 21 1948**
that I last saw him alive on **Jan 21 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia from**

Due to **Chronic Pyelonephritis**

Due to **Benign Prostatic Hypertrophy**

Other conditions (Include pregnancy within 3 months of death) **1330**

Major findings: Of operations

Of autopsy

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 **Albert H. Hoppe** (M. D. or other)

Address **601 Brentwood Blvd** Date signed **1/21/48**

Duration

1 mo

3 yrs

4 yrs

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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

Albert G. Kapp

Licensed Embalmer No..... 2971

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.

11-22-4