

No. 300
10-47
5-17-39
PI 3908

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20700

FILED JUN 21 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5271

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:
St. John's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1--Hour
(Specify whether years, months or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 4527 Forest Park Blv 9
(If rural, give location)

(e) Citizen of foreign country? 19 (Yes or No) 1
If yes, name country.....

3: (a) PRINT FULL NAME Catherine E Brooks

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7th
year 1948 hour 11 minute 30 A. M.

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow 0

6. (b) Name of husband or wife William C. Brooks

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

7. Birth date of deceased March 13 1885
(Month) (Day) (Year)

Immediate cause of death Ruptured Abdominal Aneurysm. Duration.....

Due to.....

Due to.....

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

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

63	2	24	hr. min.
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Major findings:
Of operations.....
Of autopsy.....

9. Birthplace Dont Know Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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 John Hawkins

12. Name John Hawkins

13. Birthplace Ireland #
(City, town, or county) (State or foreign country)

14. Maiden name Carlotta Johnston

15. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Miss. Naomi R. Brownstone

(b) Address 3664 Washington Blvd.

17. (a) Burial (b) Date thereof 6-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Linfield Blvd

19. (a) JUN 9 1948 (b) J. F. Brudack
(Date received local registrar) (Registrar's signature)

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

(c) Means of injury 3

22. Signature Arthur J. Donnelly (M. D. or other) 3
Date signed 6/8/48

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

MOTHER FATHER

Emerson

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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address. *3846 Lindell*

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.