

STANDARD CERTIFICATE OF DEATH

National Office of Vital Statistics
FILED AUG 12 1948 18
 Registration District No.

State File No.
6738
 Registrar's No.

Primary Registration District No.

1003

33

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.....
Bethesda General Hospital
 (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..... Mo. (b) County.....
 (c) City or town..... St. Louis, Mo. Salem
 (If outside city or town limits, write "RURAL")
 (d) Street No..... 3444 Vista Ave. Rural
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No) /
 If yes, name country.....

3. (a) PRINT FULL NAME Brown, Vera
 (b) If veteran, name war.....
 (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 23
 year 1948 hour 8:00 AM minute 9:00 - A.M.
 P.M.

4. Sex..... F 5. Color or race..... W
 6. (a) Single, widowed, married, divorced..... 0
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... May 22 1948
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 22 May 1948 to 8 AM 23 May 1948
 that I last saw h.s. alive on 23 May 1948
 and that death occurred on the date and hour registered above.
 Duration

8. AGE: Years Months Days If less than one day
11 hr. 11 min.

Immediate cause of death.....
atelectasis
Cerebral anoxia

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

Due to..... Prematurity
 Due to..... Placental separation of placenta (Caesarian Section)

10. Usual occupation.....

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

11. Industry or business.....

Major findings:
 Of operations.....
 Of autopsy.....

12. Name.....

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

14. Maiden name..... Virginia Vera Brown

15. Birthplace..... Salem, Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant..... Vera Brown
 (b) Address..... Salem, Mo. (Rural)

17. (a) Anatomical Board Date thereof JUL 31 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or removal..... Rowland Mortuary Service

18. (a) Signature of funeral director.....
 (b) Address..... 4104 Manchester Ave.

19. (a) JUL 31 1948 (b) J. J. Prodeck
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause of which death should be charged statistically.
151

Jefferson City Printing Co.

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..... C

23. Signature..... Joseph H. Decker (M. D. or other) M.D.
 Address..... 3644 Vista Ave, St Louis, Mo Date signed..... 23 May 48

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. uey
Registrar's No. 6738

Registration District No. 318

Primary Registration District No. 1003

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: _____
(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

3. (a) PRINT FULL NAME Yera Brown
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased May 22
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____
(b) Address _____

19. (a) AUG 14 1948 (b) J.F. Buleck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year _____ hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to 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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-24136