FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 31 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24981

Registration District No. 367

Primary Registration District No. 6076

Registrar's No. [illegible]

1. PLACE OF DEATH:

(a) County Rural

(b) City or town Koch,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hospital D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 56 days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 2313 Delmar
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Corrine Brown

3. (b) If veteran, name war

3. (c) Social Security No. no

4. Sex Female 3

5. Color or race Col.

6. (a) Single, widowed, married, divorced divorced 3

6. (b) Name of husband or wife Curtis Brown

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

7. Birth date of deceased June (Month) 17, [illegible] (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
39	0	28	hr. min.

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

10. Usual occupation Laundry Worker

11. Industry or business

FATHER
12. Name Mose Abron(?)
13. Birthplace Mississippi (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Jones
15. Birthplace Alabama (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-48 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director A B Harrison

(b) Address 2906 Lawton

19. (a) Jul 9 48 (Date received local registrar) Carl A. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1948 hour 9 minute 18 a M.

21. I hereby certify that I attended the deceased from 5-21-48, 19__, to 7-15-48, 19__; that I last saw her alive on 7-15-48, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 5 Mos. (?)

Due to 13 b

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? (Specify type of place)

While at work? (e) Means of injury D

23. Signature Ellis S. Lipsitz M.D. (M. D. or other)

Address Robert Koch Hospital Date signed 7-15-48

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.