

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38554**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10448**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town) St Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place) 4 yrs		b. COUNTY St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home r G Phillips Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
		d. STREET ADDRESS (If rural, give location) 3827 Winsor Place City.	

3. NAME OF DECEASED (Type or Print)	a. (First) Willie	b. (Middle) Mae	c. (Last) Brown	4. DATE OF DEATH (Month) (Day) (Year)
	/			Dec. 2 1949

5. SEX Female	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 28, 1922	9. AGE (In years last birthday) 27	IF UNDER 1 YEAR Months I	IF UNDER 24 HRS. Days 4	Hours 	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Memphis Tenn	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Will Bush	13b. MOTHER'S MAIDEN NAME Celie Allen	14. NAME OF HUSBAND OR WIFE Lee Brown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 413-34-4445	17. INFORMANT'S SIGNATURE OR NAME Lee Brown	ADDRESS 3827 Winsor Place
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous Meningitis		INTERVAL BETWEEN ONSET AND DEATH 8 days
	ANTECEDENT CAUSES		
	DUE TO (b) Undetermined		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		St Louis MO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? QIDY
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22. I hereby certify that I attended the deceased from **11-25**, 19 **49**, to **12-2**, 19 **49**, that I last saw the deceased alive on **12-2**, 19 **49**, and that death occurred at **5:35a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Herbert H. Whittier M.D.	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 12-5-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/6/49	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis MO.
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DATE REC'D BY LOCAL REG. DEC 5 1949	REGISTRAR'S SIGNATURE J. B. Sasator	25. FUNERAL DIRECTOR'S SIGNATURE Price & Dozier	ADDRESS 2829 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

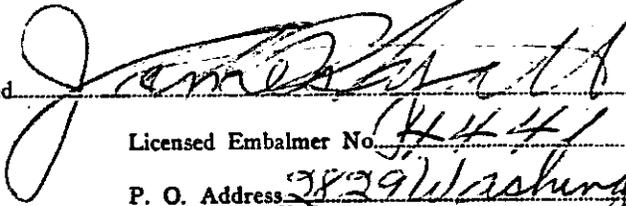
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed  _____

Licensed Embalmer No. 4441

P. O. Address 3829 Washington

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.