

FILED FEB 6 1950

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Independent city</u> <u>St. Louis, xxx</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
c. LENGTH OF STAY (In this place) <u>505 days</u>		2197	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'Reilly VA Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>4447 Delmar</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> b. (Middle) <u>L</u> c. (Last) <u>Brown</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 29 1950</u>
5. SEX <u>Male 2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>November 10 1919</u>
9. AGE (In years last birthday) <u>30</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Florida</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>-Unknown-</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>O'Reilly VA Hospital, Springfield, Mo</u>
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis, pulmonary, chronic, far advanced, active.</u>		DUE TO (b) _____	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that <u>VA</u> attended the deceased from <u>September 11, 1948</u> , to <u>January 29, 1950</u> , that <u>the deceased was deceased</u> and that death occurred at <u>1:15 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>P. L. EISELE, M.D. Chief, Professional Services</u>		23b. ADDRESS <u>VA Hospital Springfield, Missouri</u>	23c. DATE SIGNED <u>1-31-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>1-3-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	24d. LOCATION (City, town, or county) (State) <u>Douglas, Georgia</u>
DATE REC'D BY LOCAL REG. <u>2-1-50</u>	REGISTRAR'S SIGNATURE <u>W. J. Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>German-Schubert</u>	
ADDRESS <u>Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 Gene Hunter

Licensed Embalmer No. 4739

P. O. Address Springfield, MO

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.