

X No. 7
5. No. 300
10.48

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11467

State File No.

317

6076

566

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY 11	
b. CITY (If outside corporate limits, write RURAL and give town) Koch, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (in this place) 38 days		d. STREET ADDRESS (If rural, give location) 1120 N 13	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROBERT KOCH HOSPITAL			
3. NAME OF DECEASED a. (First) ESTELLA		b. (Middle)	c. (Last) BROWN
4. DATE OF DEATH MAR. 2. 1950			
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH Aug 11. 1916
9. AGE (In years last birthday) 33	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS. Mo. USA
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME REECE BROWN		13b. MOTHER'S MAIDEN NAME LUCY BANKS	14. NAME OF HUSBAND OR WIFE EDWARD DUNLAP (DIVORCED)
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. 490-12-8280	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Record - Robt Koch Hosp.
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.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 I attended the deceased from Jan 24, 1950 to Mar 2, 1950 , that I last saw the deceased alive on Mar 2, 1950 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Frank Cohen (Degree or title) MD		23b. ADDRESS Robert Koch Hosp. Koch Mo	23c. DATE SIGNED Mar 2/50
24a. BURIAL, CREMATION, REMOVAL (City) Burial	24b. DATE Mar 9/50	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem St Louis	24d. LOCATION (City, town, or county) (State) MO
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Herbert O. Dowdy MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. A. Shear 4214 Delmar	

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

4007

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

E. C. Green

..... Licensed Embalmer No. *2963*

..... P. O. Address *4714 Delmar*

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.