

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34633  
State File No. 8520  
REGISTRAR'S NO.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		REGISTRAR'S NO.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 1 mo 2 days		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Damon C. Phillips				STREET ADDRESS (If rural, give location) 3017 1/2 Easton			
3. NAME OF DECEASED (Type or Print) a. (First) Marian			b. (Middle) Brown		c. (Last) Brown		4. DATE OF DEATH (Month) (Day) (Year) 10 7 50
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH 9-5-50		9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME James Brown			13b. MOTHER'S MAIDEN NAME S. Martin		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME James Brown 3017 1/2 Easton			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 days	
		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 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 491X			
22. I hereby certify that I attended the deceased from Oct. 5, 1950, to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 6:30 p.m. from the causes and on the date stated above.							
23a. SIGNATURE A. E. Hales M.D.				23b. ADDRESS 822 N. Jefferson		23c. DATE SIGNED 10/9/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-11-50		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis	
DATE REC'D. BY LOCAL REG. OCT 9 1950		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE Howell		ADDRESS 2631 Gamble	

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

me

**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 Chas L. Howell

Licensed Embalmer No. 2452

P. O. Address 2631 Gamble

**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.