

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9926**
2678

FILED APR 9 1951

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. _____		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, Missouri		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1				d. STREET ADDRESS (If rural, give location) 2838 LAFAYETTE			
3. NAME OF DECEASED (Type or Print) a. (First) ABNER		b. (Middle) A.		c. (Last) BROWN		4. DATE OF DEATH (Month) (Day) (Year) MAR. 22 1951	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M		8. DATE OF BIRTH DEC 6 - 1965		9. AGE (In years last birthday) 85 yrs	
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) INDIANA		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME CHARLES BROWN		13b. MOTHER'S MAIDEN NAME FRANCES UNK		14. NAME OF HUSBAND OR WIFE NOAA BROWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. O. BROWN 3303 HUMPHREY			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease 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. Chronic Dyspepsia + Pericarditis of Esophagus				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK? <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H2O			
22. I hereby certify that I attended the deceased from 3-17-51 , 19____, to 3-22-51 , 19____, that I last saw the deceased alive on 3-22-51 , 19____, and that death occurred at 4:30A. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Albert M. Huggins, M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 3-22-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-24-51		24c. NAME OF CEMETERY OR CREMATORY VALHALLA		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. MAR 22 1951		REGISTRAR'S SIGNATURE J. B. Lusater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. SCHNOR 3125 LAFAYETTE			

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.....

Joe B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.