

FILED DEC 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38773

State File No. 10157

518

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO. 1005		Registrar's No. 10157			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission). a. STATE MO				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		2189			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1				d. STREET ADDRESS (If rural, give location) 4165 HERTLING PL					
3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle) S.		c. (Last) BROWN		4. DATE OF DEATH (Month) (Day) (Year) NOV. 14 1951			
5. SEX (1) MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 22 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER		10b. KIND OF BUSINESS OR INDUSTRY IRON FRY		11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME JAS BROWN		13b. MOTHER'S MAIDEN NAME NOT KNOWN		14. NAME OF HUSBAND OR WIFE MARY BROWN					
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.		17. INFORMANT'S SIGNATURE OR NAME MARY BROWN		ADDRESS St. Louis MO			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis 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. Bronchopneumonia, Malnutrition				INTERVAL BETWEEN ONSET AND 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? 602X					
22. I hereby certify that I attended the deceased from 11-6-51, 19__, to 11-14-51, 19__, that I last saw the deceased alive on 11-14-51, 19__, and that death occurred at 8:15Pm., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Walter L. Mayu M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 11-15-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE NOV. 17 1951		24c. NAME OF CEMETERY OR CREMATORY Mt. Zion		24d. LOCATION (City, town, or county) (State) St. Clair, MO			
DATE REC'D BY LOCAL REG. NOV 15 1951		REGISTRAR'S SIGNATURE J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Casey J. Lenot		ADDRESS St. Clair MO.			

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.....

H. M. Lewis

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, 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.