

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34976

FILED NOV 15 1955

State File No. \_\_\_\_\_  
Registrar's No. 9089

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. CITY OR TOWN St. Louis

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital

STREET ADDRESS (If rural, give location)  
21 912 N. Garrison

3. NAME OF DECEASED  
a. (First) Joseph b. (Middle) \_\_\_\_\_ c. (Last) Major

4. DATE OF DEATH (Month) (Day) (Year)  
10 13 55

5. SEX Male

6. COLOR OR RACE Swedish

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) \_\_\_\_\_

8. DATE OF BIRTH 25 Dec 1908 9. AGE (In years last birthday) 54

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (City and State or Foreign Country) New Orleans La

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Wm. K. Brown

13b. MOTHER'S MAIDEN NAME Wm. K. Brown

14. NAME OF HUSBAND OR WIFE \_\_\_\_\_

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) No

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT'S SIGNATURE OR NAME ADDRESS  
Myrna Innes 3203 76 Taylor

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
**MEDICAL CERTIFICATION**  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Pulmonary Tuberculosis.  
INTERVAL BETWEEN ONSET AND DEATH Undt.  
\*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  
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 Cor Pulmonale

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

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)  
002X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 10-11-, 1955, to 10-13-, 1955, that I last saw the deceased alive on 10-13-, 1955, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.

23b. ADDRESS 2601 N. Whittier Street

23c. DATE SIGNED 10-18-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 19 Oct 55

24c. NAME OF CEMETERY OR CREMATORY Oakdale

24d. LOCATION (City, town, or county) (State) St Louis MO

DATE REC'D BY LOCAL REG. OCT 18 1955

REGISTRAR'S SIGNATURE J. Earl Smith M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
Reliable Funeral Svs 1221 76 Taylor

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

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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.....  
Signature of Student Embalmer

Signed..... *Paul V Freeman*

Licensed Embalmer No. *468*

P. O. Address *4929 No*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.