

FILED MAR 28 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

10215

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **2714**

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, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Firmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) 1107 Soulard Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) ELIGE	b. (Middle) OCKE,	c. (Last) BROOKS	4. DATE OF DEATH (Month) (Day) (Year) 3-19-50
-------------------------------------	-------------------------	--------------------------	-------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-20-92	9. AGE (In years last birthday) (If under 1 year: Months) (If under 12 mos.: Days) (Hours) (Min.) 58
-----------------------	----------------------------------	--	------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Hand	10b. KIND OF BUSINESS OR INDUSTRY M.K.&T. R.R.	11. BIRTHPLACE (State or foreign country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	---

13a. FATHER'S NAME Brooks, William	13b. MOTHER'S MAIDEN NAME Lydia Pugh	14. NAME OF HUSBAND OR WIFE Christina Jett
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Christina Brooks	ADDRESS 1107 Soulard Street
--	-------------------------	--	---------------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Total cirrhosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hepatitis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Porto-caval shunt done			

19a. DATE OF OPERATION 3-16-50	19b. MAJOR FINDINGS OF OPERATION Small cirrhotic liver	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) 5810
--	--	--

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
---	--	---------------------------

22. I hereby certify that I attended the deceased from **2-3-50** to **3-19-50**, 19**50**, that I last saw the deceased alive on **3-19-50**, 19**50**, and that death occurred at **6:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE M. Scully	(Degree or title) M.D.	23b. ADDRESS 1325 S. Grand, St. Louis 4, Mo.	23c. DATE SIGNED 3-20-50
------------------------------------	----------------------------------	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-23-50	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
--	-----------------------------	--	---

DATE REC'D BY LOCAL HEALTH DEPT. APR 21 1950	REGISTRAR'S SIGNATURE J. B. Sarater	25. FUNERAL DIRECTOR'S SIGNATURE M. Josephus Sumner	ADDRESS Home 5301 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 *James R. Chipman* _____

Licensed Embalmer No. *41550* _____

P. O. Address *St. Louis, 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.