

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

 State File No. **29271**  
**7404**

FILED AUG 23 1952

 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 <b>Missouri</b> b. COUNTY <b>2159</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5364 Cabbanne avenue</b>		d. STREET ADDRESS (If rural, give location) <b>5364 Cabbanne avenue</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b> b. (Middle) <b>M.</b> c. (Last) <b>BROCK</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7-31-52</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <b>married</b> (Specify)	8. DATE OF BIRTH <b>4-2-1862</b>
9. AGE (In years last birthday) <b>90</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Case, Illinois</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brock Spec. Co.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Jacob Brock</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Flick</b>	14. NAME OF HUSBAND OR WIFE <b>Minnie Brock</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Donald Duggendorf, 5364 Cabbanne</b>
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) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Interoperiosis of arteries vasculi femoralis</b> <b>Systolic</b> DUE TO (b) 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>442X</b>
22. I hereby certify that I attended the deceased from <b>10/26</b> , 19 <b>48</b> , to <b>7/31</b> , 19 <b>52</b> , that I last saw the deceased alive on <b>7/30</b> , 19 <b>52</b> , and that death occurred at <b>5:30</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>J. E. Sommer</b>		23b. ADDRESS <b>D.O. 2165049 Belmar</b>	23c. DATE SIGNED <b>7/31/52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>7-31-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Fairfield, Illinois</b>
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Dixon-Crippen, Fairfield, Ill.</b>	
DATE REC'D BY LOCAL REG. <b>AUG 2 1952</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	

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

*[Handwritten Signature]*

Licensed Embalmer No. *366*

P. O. Address *[Handwritten Address]*

**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.