

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **10053**

FILED NOV 6 - 1953

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 Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Maplewood	
c. LENGTH OF STAY (In this place) 1-day		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital		e. STREET ADDRESS (If rural, give location) 3525 Commonwealth Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Edith b. (Middle) Whiteside c. (Last) Brockman			4. DATE OF DEATH (Month) (Day) (Year) Oct. 20, 1953
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Jan. 16, 1912
9. AGE (In years last birthday) 41		10. MONTHS 9	11. DAYS 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Clarksville, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Jay J. Whiteside	
13b. MOTHER'S MAIDEN NAME Edith Fern		14. NAME OF HUSBAND OR WIFE Mr. Harry J. Brockman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mr. Harry J. Brockman		ADDRESS 3525 Commonwealth Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Ca of Colon & Intestines		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Colon & Intestines	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		INTERVAL BETWEEN ONSET AND DEATH 3 mon.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 153X			
22. I hereby certify that I attended the deceased from 8-1-1953 to 10-20-1953 , that I last saw the deceased alive on 10-20-1953 and that death occurred at 8:10 p.m. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Byron Burr M.D.		23b. ADDRESS 3720 Wash. Ave.	
23c. DATE SIGNED 10-21-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Oct. 23, 1953	
24c. NAME OF CEMETERY OR CREMATORY Centralia Cemetery		24d. LOCATION (City, town, or county) (State) Centralia, Mo.	
DATE REC'D BY LOCAL REG. OCT 21 1953		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 810 Lindell Blvd.	

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 me....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James S. Latham.....

Licensed Embalmer No. 4699.....
P. O. Address St. Charles.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.