

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44737**

FILED JAN 11 1954

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>3340</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis, Co.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>UNK</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Manchester</u>		c. LENGTH OF STAY (in this place) <u>34 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>UNK</u>		d. STREET ADDRESS (If rural, give location) <u>UNK</u> <u>4000</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pine Crest Nursing Home</u>							
3. NAME OF DECEASED a. (First) <u>John</u> (Type or Print)			b. (Middle) <u>Chas</u>		c. (Last) <u>Brown</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13 1953</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>UNK</u>	8. DATE OF BIRTH <u>UNK</u>		9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNK</u>	
13a. FATHER'S NAME <u>UNK</u>		13b. MOTHER'S MAIDEN NAME <u>UNK</u>		14. NAME OF HUSBAND OR WIFE <u>UNK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Pine Crest Nursing Home</u>		ADDRESS <u>RECORDS</u>	
19. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute cardiac dilatation</u>					<u>1 day</u>
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) _____					<u>2 yrs.</u>
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 <u>4222</u>					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)			
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 <u>11-26-</u> , 19 <u>53</u> , to <u>12-13</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>53</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. A. Sheslie MD</u> (Degree or title)		23b. ADDRESS <u>Kirkwood, Mo</u>		23c. DATE SIGNED <u>12/10/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>		24b. DATE <u>3</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Stand</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis - Mo.</u>		
DATE REC'D BY LOCAL REG. <u>12/28/53</u>		REGISTRAR'S SIGNATURE <u>Walter B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rouland ARL</u>		ADDRESS <u>4104 Manchester</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

P. O. 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.