

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5967

1003 State File No.
Registrar's No. 1304

FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO.

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	
c. LENGTH OF STAY (in this place) 25 yrs.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 4450 Cote Brillante 2119	

3. NAME OF DECEASED (Type or Print) Edward Brock	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Feb. 7 1954
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 18, 1904	9. AGE (In years) 49	# UNDER 1 YEAR 10	# UNDER 1 MIN. 19
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blind Broom Salesman	10b. KIND OF BUSINESS OR INDUSTRY Broom	11. BIRTHPLACE (City and State or Foreign Country) Ellisville, Mississippi	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Thomas L. Brock	13b. MOTHER'S MAIDEN NAME Lillie (?)	14. NAME OF HUSBAND OR WIFE Mary Brock
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Brock, 4450 Cote Brillante
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c) None II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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 331X
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22. I hereby certify that I attended the deceased from 2-6-1954, to 2-7-1954, that I last saw the deceased alive on 2-1-1954, and that death occurred at 6:50 P. M., from the causes and on the date stated above.

23a. SIGNATURE Edw. B. Williams M. D.	(Degree or title) <input type="checkbox"/>	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 2-9-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/11/54	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery St. Louis Co., Missouri	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. FEB 10 1954	REGISTRAR'S SIGNATURE Charles J. Gates	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles J. Gates, 4107 Finney Ave.
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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.....
Signature of Student Embalmer

Signed *Arthur L. Hilliard*.....

Licensed Embalmer No. 4221.....

P. O. Address 4107 Finne.....

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.