

BIRTH NO. _____ 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 1217 Armstrong		2227/0	

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle)	c. (Last) Brockman	4. DATE OF DEATH (Month) (Day) (Year) 4 30 54
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 17, 1902	9. AGE (In years last birthday) 51	10. UNDER 1 YEAR Months 5	11. UNDER 1 YEAR Days 13	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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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) Montevallo, Ala.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Wm. Mcpherson	13b. MOTHER'S MAIDEN NAME McCurry	14. NAME OF HUSBAND OR WIFE Sanford Jones
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mattie Nichols	ADDRESS 2819 Lasalle St.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Prob. Ulcerative Colitis - Chronic Chronic Constipation	

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) 443X
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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?
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22. I hereby certify that I attended the deceased from 3-22, 1954, to 4-30, 1954, that I last saw the deceased alive on 4-30, 1954, and that death occurred at 8:10A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Earl Belle Smith M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 5-1-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/5/54	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetary	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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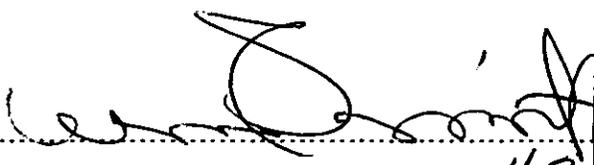
DATE REC'D BY LOCAL REG. MAY 3 1954	REGISTRAR'S SIGNATURE Earl Belle Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Smith	ADDRESS 4019 Washington Blvd.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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.....


Licensed Embalmer No. 43

P. O. Address St. Paul

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.