

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13158

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3350

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>23 2012 Shenandoah</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>HENRY</u> c. (Last) <u>BROWNFIELD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 13, 1955</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12-19-1877</u>		9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
--------------------	--	-------------------------------	--	---	--	------------------------------------	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ava, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
---	--	--	--	---	--	--	--

13a. FATHER'S NAME <u>Henry Brownfield</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Stella Brownfield</u>	
--	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Stella Brownfield, 2012 Shenandoah</u>	
--	--	----------------------------------	--	---	--

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>P. Aeruginosa septicemia</u> ANTECEDENT CAUSES <u>Acute cholecystitis</u> DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
--	--	---	--	--	--	----------------------------------	--

19a. DATE OF OPERATION <u>4-4-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>acute cholecystitis & cholelithiasis</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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>584x</u>	
--	--	--	--	--	--

22. I hereby certify that I attended the deceased from 3-31-55, 1955, to 4-13-55, 1955, that I last saw the deceased alive on 4-13-55, 1955, and that death occurred at 5:15A m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. Carl Smith M.D.</u> (Degree or title)			23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>4-13-55</u>
--	--	--	---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-15-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sparta, Illinois</u>		24d. LOCATION (City, town, or county) (State)	
--	--	----------------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. <u>APR 14 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>McLaughlin F.H., Inc., 2301 Lafayette</u>	
---	--	---	--	---	--

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.....

Licensed Embalmer No. 45

P. O. Address St. Louis

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.