

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14281

FILED MAY 12 1955

State File No. _____

Registrar's No. 970

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500

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| 1. PLACE OF DEATH a. COUNTY St Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay | | c. CITY OR TOWN Columbia | |
| c. LENGTH OF STAY (in this place) 2 1/2 months | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Mt St Rose Hospital | | | |
| e. STREET ADDRESS (If rural, give location) R R 1 | | | |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type of Print) a. (First) Minnie b. (Middle) A c. (Last) Brooks | | | 4. DATE OF DEATH (Month) (Day) (Year) April 26 1955 | | |
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|----------------------|--|-------------------------------|--|---|--|-------------------------------------|--|---|--|---|--|---|--|
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH June 3 1888 | | 9. AGE (in years last birthday) 66 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ 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 at home | | | 11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo. | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
|--|--|--|--|--|--|--|--|--|---|--|--|

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|--|--|--|---|--|--|--|--|--|
| 13a. FATHER'S NAME William Dvorak | | | 13b. MOTHER'S MAIDEN NAME Amelia Schultz | | | 14. NAME OF HUSBAND OR WIFE George M. | | |
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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) | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS George M. Brooks R R 1 Columbia Ill | | | |
|--|--|-------------------------------------|--|--|--|--|--|

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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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Fibrosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 + yrs | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Tuberculosis | | | | | | 7 + yrs | |
| | | DUE TO (c) _____ | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 002X | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <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 **10-1 1952**, to **4-26 1955**, that I last saw the deceased alive on **4-23 1955**, and that death occurred at **5:45 Am.**, from the causes and on the date stated above.

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| 22a. SIGNATURE (Degree or title) John C. Muehleisen, M.D. | | | 23b. ADDRESS 3720 Washington Blvd | | | 23c. DATE SIGNED 4-26-55 | | |
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| 24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) | | 24b. DATE 4/29/55 | | 24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery | | 24d. LOCATION (City, town, or county) (State) St Louis County Mo. | |
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| DATE REC'D BY LOCAL REG. 4/27/55 | | REGISTRAR'S SIGNATURE Harvey P. Donke, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av | |
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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 *Reinhold K. Lohman*

Licensed Embalmer No. *3390*

P. O. Address *St. Louis 4*

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.