

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 26 1957

State File No. **25970**  
Registrar's No. **6521**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>6521</b>			
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>					
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>26 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Collinsville</b>		<b>8/20</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>22 St. Anthony's</b>				d. STREET ADDRESS (If rural, give location) <b>32 Belt Line 40</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>HELEN</b>		b. (Middle) <b>BARBARA</b>		c. (Last) <b>BRAVIN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>7 14 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>		8. DATE OF BIRTH <b>Nov. 5, 1934</b>			
9. AGE (In years last birthday) <b>22</b>		IF UNDER 1 YEAR Months		IF UNDER 1 HRS. Hours		IF UNDER 1 MIN. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Bldg. Designers</b>			11. BIRTHPLACE (State or foreign country) <b>Sawyer ville, Ill.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13a. FATHER'S NAME <b>Ernest Bravin</b>		13b. MOTHER'S MAIDEN NAME <b>Frances Dobornic</b>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-34-8660</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ernest Bravin</b>				ADDRESS <b>Collinsville, Ill.</b>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CHRONIC GLOMERULO-NEPHRITIS WITH TERMINAL UREMIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS.</b>	
		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. <b>592x</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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?					
22. I hereby certify that I attended the deceased from <b>1/4/1948</b> , to <b>7/14/1957</b> , that I last saw the deceased alive on <b>7/14/1957</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Robert W. Warner M.D.</b>				23b. ADDRESS <b>818 OLIVE ST</b>			23c. DATE SIGNED <b>7/15/57</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7/17/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>		24d. LOCATION (City, town, or county) (State) <b>Collinsville Ill.</b>			
DATE REC'D BY LOCAL REG. <b>III 15 57</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Hubert R. East</b>				
					ADDRESS <b>Collinsville, Ill.</b>				

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 \_\_\_\_\_

*Embalmer* Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 6890

P. O. Address Collinsville, Ill.

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.