

Health, Welfare, Public Service

300 -57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 4 1957

29259  
STATE FILE NUMBER  
7747  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 City Hospital		d. STREET ADDRESS (If outside, give location) 221/8 3148 Olive st.	
3. NAME OF DECEASED (Type or print) First Middle Last OLLIE BROOKS		4. DATE OF DEATH Month Day Year 8-15-57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1900
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber	11. BIRTHPLACE (City and state or country) Tennessee
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber		10b. KIND OF BUSINESS OR INDUSTRY barber	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME J. C. Brooks		13b. MOTHER'S MAIDEN NAME Imogene Maxwell	14. NAME OF HUSBAND OR WIFE unknown
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. unknown	17. INFORMANT Address Jos. Brooks, Mallup, New Mexico,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hematoma</i> <i>Lobar Pneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Lobar Pneumonia</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Signature of informant in PART I or PART II of item 18.) <i>E904.021</i> <i>fell from balcony of house of</i>	
20c. TIME OF INJURY Hour Month, Day, Year 8 15 57		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN OR LOCATION St Louis Mo.	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <i>Patrick Taylor Carraway</i>		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>8-19-57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 8-17-57	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (Specify) Cape Girardeau, Mo.	
24. FUNERAL DIRECTOR Haman, Cape Girardeau, Mo.		25. DATE RECD. BY LOCAL REG. AUG 19 57	
26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> <i>S.P.</i>			

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

*Homer H. Jr.*

Licensed Embalmer No. ....

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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.