

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 10 1957

41798  
STATE FILE NUMBER  
11482

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Clay</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Brazil</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b		d. STREET ADDRESS <b>33 Rural Route No. 2</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>VICTOR</b> Last <b>BROWN</b>			4. DATE OF DEATH <b>NOVEMBER 29, 1957</b> Month <b>NOVEMBER</b> Day <b>29</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 5, 1901</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Int'l Harvester Co.</b>		11. BIRTHPLACE (City and state or country) <b>Vermillion, Illinois.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Robert Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Golda Evinger</b>		14. NAME OF HUSBAND OR WIFE <b>Della Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Della Brown, Brazil, Indiana, R.R. No. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>162+</b>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Nov. 24, 1957</b> to <b>NOV. 29, 1957</b> and last saw her/him alive on <b>NOV. 29, 1957</b> Death occurred at <b>2:40 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>C. J. Vermillion, M.D.</i> - M. D.			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>11/30/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-30-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Paris, Illinois.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>NOV. 30 1957</b>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> G.C.M.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Edna R. Rutledge*  
Licensed Embalmer No. *4077*  
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.