

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007049  
State File No.

FILED MAR 5 - 1958

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2400**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St, Louis</b>		c. CITY OR TOWN <b>St. Louis</b>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. LENGTH OF STAY (in this place) <b>4 mo.</b>		e. STREET ADDRESS (If rural, give location) <b>2170 2208a Franklin</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Will</b>		b. (Middle)		c. (Last) <b>Brown</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>2-24-58</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>col</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>7-1-1896</b>		9. AGE (In years last birthday) <b>61</b> IF UNDER 1 YEAR Months Days IF UNDER 4 Wks. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pensioner</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>unk. Will Brown</b>		13b. MOTHER'S MAIDEN NAME <b>unk. Roxie A. Smith</b>	
14. NAME OF HUSBAND OR WIFE <b>Single</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW1</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>Sam Brown</b>		18. ADDRESS <b>508 W. 6 Cincinnati Ohio</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Artery Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>stat</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>		<b>4 mo.</b>	
		DUE TO (c) <b>Generalized Arteriosclerosis</b>		<b>4 mo.</b>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>332x</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)		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>10-16-57</b> , 19___, to <b>2-24-58</b> , 19___, that I last saw the deceased alive on <b>2-24-58</b> , 19___, and that death occurred at <b>1:30 A. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>		23b. ADDRESS <b>5800 Arsenal St.</b>		23c. DATE SIGNED <b>2/24/58</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>2-28-58</b>		24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery Jefferson Baricks Mo</b>	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE <b>Gus Howe</b>		25. ADDRESS <b>2950 Dickson St</b>	
DATE REC'D BY LOCAL HEALTH DEPT. <b>FEB 27 58</b>		REGISTRAR'S SIGNATURE <b>Paul Smith Mo</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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Leroy H. Gannister*

Licensed Embalmer No. *452*

P. O. Address *4257 W. Hudson*

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.