

Health,  
Welfare  
Public  
Service

FILED MAR 18 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011390  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2380**

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
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"/>	a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>
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 (If outside, give location) <b>151 Sumner Blvd</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
<b>ELLEN</b>	<b>NMN</b>	<b>BREEZE</b>	<b>FEBRUARY</b>	<b>25</b>	<b>1958</b>	

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 27, 1892</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Tonbridge, Kent, England</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>George Thomas Brotherwood</b>	13b. MOTHER'S MAIDEN NAME <b>Ester Cheeseman</b>	14. NAME OF HUSBAND OR WIFE <b>John Breeze</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Collinsville, Ill.</b>	Address <b>Collinsville, Ill.</b>
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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>ADENOCARCINOMA OF LUNG</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) \_\_\_\_\_

163x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>DILATATION OF ESOPHAGUS, CHRONIC 11 YEARS</b>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 AT 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
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21. I attended the deceased from <b>JULY, 1956</b> to <b>FEB. 25, 1958</b> and last saw her alive on <b>FEB. 25, 1958</b> Death occurred at <b>12:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>David Hafe Kerr M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>2/25/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/28/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Collinsville, Ill.</b>
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24. FUNERAL DIRECTOR <b>Herr Funeral Home</b>	ADDRESS <b>Collinsville, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 27 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 ..... Not embalmed  
Vince Herr, Jr.  
Licensed Embalmer No. 3577.....  
P. O. Address...Collinsville, Mo., 11

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.