

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030199  
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7819

S. 300  
1-57  
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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 Jewish Old Home		d. STREET ADDRESS (If outside, give location) 1338 E. Grand	
3. NAME OF DECEASED (Type or print) First Middle Last Rose Brockman		4. DATE OF DEATH Month Day Year August 11, 1958	
5. SEX female	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 About 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Poland
13a. FATHER'S NAME Louis Pontz		13b. MOTHER'S MAIDEN NAME Helen (unk)	14. NAME OF HUSBAND OR WIFE Morris Brockman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. M. Bain 1123 N. McKnight Rd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with Left Hemiplegia</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>Yrs.</u> <u>Yrs.</u>
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	
21. I attended the deceased from <u>1954</u> to <u>Aug. 11, 1958</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>8/10/58</u> . Death occurred at <u>4:00</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ray J. Pearson MD</u> (Degree or title)		22b. ADDRESS <u>4652 Maryland.</u>	22c. DATE SIGNED <u>8/12/58</u>
23a. BURIAL, CREMATION REMOVAL (Specify) removal	23b. DATE <u>8/12/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Amoona Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Univ. City, Mo.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>AUG 1 2'58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>M. H. B.</u>

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 *James G. Ludwig*  
Licensed Embalmer No. 4259  
P. O. Address.....

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.