

Health & Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037637

STATE FILE NUMBER

FILED NOV 10 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10130

S. 300 C  
1-57

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, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 440 Missouri Pacific		Length of stay in lb One Week	d. STREET ADDRESS 4018 Castleman		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lon R. Brooks			4. DATE OF DEATH Month Day Year 10-21-58		
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1891	9. AGE (In years last birthday) 67	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith helper		10b. KIND OF BUSINESS OR INDUSTRY Mo. Pacific R.R.	11. BIRTHPLACE (City and state or country) Cuba, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Robert Brooks		13b. MOTHER'S MAIDEN NAME Dora Wade		14. NAME OF HUSBAND OR WIFE Hilda Schober Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Address Hilda Brooks 4018 Castleman		
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>Coronary Occlusion</i> DUE TO (b) <i>Coronary Sclerosis</i> DUE TO (c) <i>Fracture of Right Femur</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Do not refer to the terminal disease condition given in PART I.) <i>late perforated duodenal ulcer</i>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Time, place, activity, if any, and other pertinent facts) <i>while Harry Dickson, was the intersection of 59th and Shaw St. about 700 p.m. October 9 1958.</i>				
20c. TIME OF INJURY Hour Month, Day, Year <i>7:00 p.m. 10 9 58</i>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>17 Street</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Louis Mo.</i>			
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <i>4 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James M. Kelly, Deputy</i>			22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>10-23-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>10-25-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bellefontaine</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo</i>	
24. FUNERAL DIRECTOR <i>Weick Bros</i>		ADDRESS <i>2201 S. Grand Blvd</i>	25. DATE RECD. BY LOCAL REG. <i>OCT 23 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>	

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 *Harvey E. Kable* .....

Licensed Embalmer No. *4596* .....  
P. O. Address *Flouissant, Mo.* .....

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.