

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042629

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 3018

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-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Kirkwood</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>240 W. Argonne Dr.</b>		Length of stay in 1b <b>60 years</b>	d. STREET ADDRESS (If outside, give location) <b>240 W. Argonne Drive</b>

3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>E.</b> Last <b>BROSSARD</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1871</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>	11. BIRTHPLACE (City and state or country) <b>Fenton, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Peter Brossard</b>	13b. MOTHER'S MAIDEN NAME <b>Cornelia Tising</b>	14. NAME OF HUSBAND OR WIFE <b>Single</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>Ambrose Brossard, 339 S. Gore Ave. Webster Gr.</b>	Address
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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>Cerebral Concussion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10. month</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	900.0
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral arterial sclerosis 21</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input checked="" 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.) <b>She fell down stairs at home.</b>
20c. TIME OF INJURY <b>7:25 am 11/18/58</b>	125

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>Kirkwood</b> COUNTY <b>Jefferson</b> STATE <b>MO.</b>
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21. I attended the deceased from <b>11/18/58</b> , to <b>11/18/58</b> and last saw her <b>alive</b> on <b>11/18/58</b> Death occurred at <b>7:25</b> <b>A</b> m 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>Charles R. Burnside M.D.</b>	22b. ADDRESS <b>206 N. Clay, Kirkwood</b>	22c. DATE SIGNED <b>11/18/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/21/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kirkwood, Mo.</b> (State)
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24. FUNERAL DIRECTOR <b>Louis H. Bopp Inc. Kirkwood Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11-20-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Danke M.D.</b>
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(Dispensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 \_\_\_\_\_

Licensed Embalmer No. 4517

P. O. Address Richard, 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.