

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002779  
State File No. **2 1011**

No. 300  
10. 48

FILED FEB 10 1959

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Saint Louis Maternity</b>		e. STREET ADDRESS (If rural, give location) <b>5856 Ridge 2069</b> <b>0</b>	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) <b>Brown</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 20 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Jan 18 1959</b>
9. AGE (In years last birthday) <b>2</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 14 HRS. Hours <b>0</b> Min. <b>45</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Richard Lee Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Clytee NMN Scott</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>			
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'S SIGNATURE OR NAME ADDRESS <b>Richard &amp; Clytee Brown 5856 Ridge</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Anemia</b> DUE TO (c) <b>fetal distress. 760.0</b> 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>1/18</b> , 19 <b>59</b> , to <b>1/20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/20</b> , 19 <b>59</b> , and that death occurred at <b>12:10A</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Richard L. Brown MD</b>		23b. ADDRESS <b>St. Louis Maternity Hospital</b>	
23c. DATE SIGNED <b>1-21-59</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>1-31-59</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 29 59</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Carl Smith McRowland Ave 4104 Manchester</b> <b>m.s.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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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.....

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.