

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002783

STATE FILE NUMBER

1003

54

FILED JAN 26 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 54

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, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, or institution) HOSPITAL OR INSTITUTION <b>St. Ann's Hospital</b>		Length of stay in lb	d. STREET ADDRESS <b>3715 Fair</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George Ray Brown</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>1</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12 26 1924</b>	9. AGE (In years last birthday) <b>34</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
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>housewife</b>	11. BIRTHPLACE (City and state of country) <b>Miss' U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Ray</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Lawson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or of unknown) (If unknown, give dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>970</b>	17. INFORMANT <b>Marcel Brown</b> Address <b>3715 Fair</b>		
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>Internal Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>External Hemorrhage</b>					
DUE TO (c) <b>Traumatic Amputation of left leg</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>suffered when struck by pipe operated by one David [unclear] at the intersection of Fair and Natural Bridge Ave. about 145 am., January 1, 1959.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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, item 18.) <b>pipe at the intersection of Fair and Natural Bridge Ave.</b>				
20c. TIME OF INJURY Hour <b>145</b> Month, Day, Year <b>1 1 59</b>	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, hotel, office bldg., etc.) <b>Street</b>
			20f. CITY, TOWN, OR LOCATION <b>St Louis Mo</b>		STATE <b>MO</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>2:10 Am on the date stated above; and to the best of my knowledge, from the causes stated.</b>					
22a. SIGNATURE <b>Agnes [unclear]</b> (Degree of title)			22b. ADDRESS <b>1300 Chest</b>		22c. DATE SIGNED <b>1/2/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>5 Jan. 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Missouri</b>	
24. FUNERAL DIRECTOR <b>Reliable Funeral Sys. 1389 N. Union</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 5 59</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes. Part 1 must be causally related. Diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 e  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*John K. Cummins*

Licensed Embalmer No. *42*

P. O. Address *2405 2*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.