Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003692
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 107

1. PLACE OF DEATH
a. COUNTY ST-LOUIS
b. CITY OR TOWN CLAYTON 5, Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST-LOUIS COUNTY Length of stay in 1b 5 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST-LOUIS
c. CITY OR TOWN FENTON 4000 Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) R.R. 1, BOX 446 Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: JOHN Middle: Last: BROZ
4. DATE OF DEATH Month 1 Day 9 Year 59
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH JAN. 25, 1880
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED — FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (City and state or country) DENNISON, TEXAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JOHN BROZ
13b. MOTHER'S MAIDEN NAME SUSAN MINARD
14. NAME OF HUSBAND OR WIFE MARY ELIZABETH BROZ
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO.
17. INFORMANT MARY E. BROZ, Address FENTON, MO. RR. #1, BOX 446

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriolar Nephrosclerosis — 1/4/59
DUE TO (c) — 1/9/59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Carcinoma of Prostate, metastatic 4/1/6 XH
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 1-4-59, to 1-9-59 and last saw her/him alive on 1-9-59
Death occurred at 6:25 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Angelo A. Spero MD (Degree or title)
22b. ADDRESS 601 So. Brentwood
22c. DATE SIGNED 1/10/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 1-13-59
23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY
23d. LOCATION (City, town, or county) (State) KIRKWOOD, MO.

24. FUNERAL DIRECTOR PFITZINGER ADDRESS KIRKWOOD, MO.
25. DATE RECD. BY LOCAL REG. 1-11-59
26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.
(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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 V. E. Morris

Licensed Embalmer No. 3360

P. O. Address St. Louis, 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.