

Health, Welfare
Public
Service

Trans. from Park Lane Hospital

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010741
STATE FILE NUMBER
2 2122

8-4-59

MAR 17 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
1-57
36
94
0

1. PLACE OF DEATH 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, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		Length of stay in 1b 10hrs 17 min.	d. STREET ADDRESS 1031 Lafayette (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Malcodene Marie Brewer			4. DATE OF DEATH 2/27/59
First	Middle	Last	Month Day Year

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/51	9. AGE (In years last birthday) 8	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Herbert Wiley Brewer	13b. MOTHER'S MAIDEN NAME Ollouise Rall	14. NAME OF HUSBAND OR WIFE never married
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Ida Toibb, 500 S. Kingshighway	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) Cerebral edema, marked CONDITION WHICH GAVE RISE TO ABOVE (b) Hepatic coma UNDERLYING CAUSE (c) Etiology undetermined		INTERVAL BETWEEN ONSET AND DEATH 2 d.s. 2 d.s. —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis, Missouri	COUNTY	STATE
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21. I attended the deceased from 2/27/59 to 2/27/59 and last saw ^{her} _{him} alive on 2/27/59 Death occurred at 10:22 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Richard H. Smith M.D. (Degree or title)	22b. ADDRESS 500 S. Kingshighway	22c. DATE SIGNED 2/28/59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE March 2, 1959	23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery	23d. LOCATION (City, town, or county) Sheridan, Arkansas	(State)
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24. FUNERAL DIRECTOR Witt Bros. 2929 S. JEFFERSON	25. DATE RECD. BY LOCAL REG. MAR 2 '59	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
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Director, 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 *Herbert J. Goss, Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Kidwood 22, 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.