

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014756

STATE FILE NUMBER

2 3744

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3031 MAGAZINE		d. STREET ADDRESS (If outside, give location) 3031 MAGAZINE	

3. NAME OF DECEASED (Type or print) First Middle Last DANIEL BROYLES			4. DATE OF DEATH Month Day Year 4 15 59		
5. SEX MALE	6. COLOR OR RACE NEGRU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-58	9. AGE (In years last birthday) 5 10	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME WALTER BROYLES		13b. MOTHER'S MAIDEN NAME HELEN FOWLER		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS HELEN BROYLES 3031 MAGAZINE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonia			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 525x			
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE	

21. Attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at **730A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 4/16/59	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-19-59		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO	
24. FUNERAL DIRECTOR ELIZABETH LOVE 3103 WASHINGTON			25. DATE RECD. BY LOCAL REG. APR 16 '59		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

mjc

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 *W. Claude Gordon*

Licensed Embalmer No. *3489*
P. O. Address *4575 Alder*

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.