

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016949  
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 153

1. PLACE OF DEATH  
a. COUNTY Callaway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Mo b. COUNTY St Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brunon Inside Limits Yes  No

c. CITY OR TOWN Robertson Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp #1 Length of stay in 1b 9 yrs

d. STREET ADDRESS (If outside, give location) Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First James Middle Garfield Last Brooks

4. DATE OF DEATH Month 5 Day 27 Year 59

5. SEX M

6. COLOR OR RACE Col

7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED

8. DATE OF BIRTH 12-31-87

9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) coal

10b. KIND OF BUSINESS OR INDUSTRY coal

11. BIRTHPLACE (City and state or country) Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Brooks

13b. MOTHER'S MAIDEN NAME Mary Thomas

14. NAME OF HUSBAND OR WIFE Shelton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) (P)

16. SOCIAL SECURITY NO. DK

17. INFORMANT Address BRENTWOOD MO  
ANSTES ROBINSON 1434 HATHWAY

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) atherosclerotic heart disease  
Insanition  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_

Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.

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  NO

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 \_\_\_\_\_ Month, Day, Year \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

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.) State Hospital #1

20f. CITY, TOWN, OR LOCATION COUNTY STATE  
Dec, 15 1950 to May 27, 1959

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and he was her alive on \_\_\_\_\_  
Death occurred at 9.20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. Don Carthy MD

22b. ADDRESS State Hosp #1

22c. DATE SIGNED 5-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify) 6/1/59

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY

23d. LOCATION (City, town, or county) (State) ST LOUIS MO

24. FUNERAL DIRECTOR ADDRESS FORBES FUNERAL HOME

25. DATE RECD. BY LOCAL REG. May-27-1959

26. REGISTRAR'S SIGNATURE Maretha Lawrence

3028-D-580B ST (Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *H. Claude Gordon* .....

Licensed Embalmer No. *3489* .....

P. O. Address. *1123 N. Jay* .....

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.