

Health,
& Welfare
Public
Service

FILED VS JUL 21 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-027410

Registration District No. 317 Primary Registration District No. 541 REGISTRAR'S No. 1704

STATE FILE NO.

300
1-57

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis.</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton, Missouri.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Pine Lawn.</u> 4157 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Enroute County Hospital</u> | | Length of stay in 1b. | d. STREET ADDRESS (If outside, give location) <u>6228 Dardenella</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Brown Jr.</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 22, 1905</u> | 9. AGE (In years last birthday) <u>54</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Black & White Cab</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>John Brown Sr.</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ruby Brown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>Nil.</u> | 17. INFORMANT <u>Ruby Brown, 6228 Dardenella Pine Lawn, Mo.</u> 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) <u>Far Advanced Pulmonary Tb.</u> | | 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) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CO2 X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 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 _____ 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. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>John C. Murphy M.D.</u> (Degree or title) | | 22b. ADDRESS <u>801 So. Brentwood, Clayton</u> | | 22c. DATE SIGNED <u>7/6/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL <u>Removal</u> | | 23b. DATE <u>6-25-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Local</u> | 23d. LOCATION (City, town, or county) (State) <u>New Providence, Kentucky.</u> |

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| 24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., Benton, Kentucky.</u> | 25. DATE RECD. BY LOCAL REG. <u>6-25-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Lawrence O. Herling*

Licensed Embalmer No. *4979*

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.