

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1959

59-030997

INDEXED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2048 STATE FILE NUMBER

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> </u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND - HEIGHTS</u>		Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S - HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1827 A. HOGAN - ST.</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE-ANNA-BROCKLAND</u>		4. DATE OF DEATH Month Day Year <u>JULY-30TH 1959</u>	

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1876</u>	9. AGE (last birthday) <u>82 YRS.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS - MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	

13a. FATHER'S NAME <u>AUGUST - BROCKLAND</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH-OVERBECK</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER - MARRIED</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>NONE</u>		17. INFORMANT Address <u>JOSEPH-F. BROCKLAND-6427-PERNOD-AV.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>			<u>3 days</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>			<u>7 yrs.</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>			<u>7 yrs.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			

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	COUNTY	STATE
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21. I attended the deceased from 1950 to present and last saw her/him alive on July 30, 1959
Death occurred at 1:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul G. Bettowell M.D.</u>		22b. ADDRESS <u>1695 S. Brentwood Blvd</u>		22c. DATE SIGNED <u>July 31, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG. 3RD 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY - CEMETERY</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS MO.</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Brockland Und. Co. 1827-HOGAN-ST.</u>	25. DATE RECD. BY LOCAL REG. <u>7-31-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J W M B Embler

Licensed Embalmer No. 3653

P. O. Address St Louis 8

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.