OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 23 1959

2 9441 59-037445

STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis Maternity

Inside Limits: Yes ☐ No ☐

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

c. CITY OR TOWN: St. Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 3879 Delmar

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First | Middle | Last: Brown

4. DATE OF DEATH: Month October Day 7 Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10-5-59

9. AGE (last birthday) | IF UNDER 1 YEAR: Months | Days 1 | IF UNDER 24 HR: Hours 22 | Min. 25

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: United States

13a. FATHER'S NAME: Alfred Haywood Brown

13b. MOTHER'S MAIDEN NAME: Etta Mae Hicks

14. NAME OF HUSBAND OR WIFE: None

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

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Alfred & Etta Brown Address: 3879 Delmar

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY FAILURE

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

DUE TO (b): HYLINE MEMBRANE, BILATERAL

DUE TO (c): PREMATURITY

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

INTRAVENTRICULAR HEMORRHAGE

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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

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.)

20f. CITY, TOWN, OR LOCATION | COUNTY | STATE

21. I attended the deceased from Oct. 5, 1959, to Oct. 7, 1959 and last saw ~~him~~ him alive on Oct. 7, 1959

Death occurred at 8:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. Murphy M.D.

22b. ADDRESS: St. Louis Maternity Hospital

22c. DATE SIGNED: 10-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 10-31-59

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland Aker ADDRESS: 4104 Manchester

25. DATE RECD. BY LOCAL REG.: OCT 15 '59

26. REGISTRAR'S SIGNATURE: Hoard Smith M.D. MFB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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