

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 46 1 40

FILED VS JAN 11 1960 317

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3.399

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) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Lemay</u> 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>St. Louis County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8523 Idaho</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>George J. Brown</u>			4. DATE OF DEATH Month Day Year <u>December 20 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>8/1/1908</u>	9. AGE (last birthday) <u>51</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>Paper Cutter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>National Cover Co.</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</u>	13b. MOTHER'S MAIDEN NAME <u>Carrie Westendorf</u>	14. NAME OF HUSBAND OR WIFE <u>Martha</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>488 09 5890</u>	17. INFORMANT Address <u>Martha Brown 8523 Idaho Lemay, Missouri</u>
--	--	--

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>Gunshot wound of abdomen</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Self inflicted gunshot wound of abdomen</u>
--	--	--

20c. TIME OF INJURY Hour a.m. or p.m. <u>8:00 a.m.</u> Month, Day, Year <u>12/20/59</u> <u>body found</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>rear exterior of home premises</u>	20f. CITY, TOWN, OR LOCATION <u>Lemay</u> COUNTY <u>St. Louis</u> STATE <u>Missouri</u>
--	---	--	---

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.

22a. SIGNATURE <u>Raymond Hand</u> (Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Clayton, Mo.</u>	22c. DATE SIGNED <u>12/29/59</u>
---	----------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lemay, Missouri</u>
---	--------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries 7814 So. Broadway St. Louis, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>12-21-59</u>	REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
---	--	--

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 Lenis C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Br

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.