

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-003176

FILED VS. JAN 22 1960

Registration District No. 1960 Primary Registration District No. 2 Registrar's No. 159 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>77-yrs.</u>	c. CITY OR TOWN <u>St. Louis</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. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5301 Page Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Mary</u> Last <u>Brazill</u>			4. DATE OF DEATH Month <u>January</u> Day <u>4th.</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>9/25/1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Sec'y. - Master Builders Ass'n.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Norwich, Conn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>James Brazill</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Sullivan</u>		14. NAME OF HUSBAND OR WIFE	
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>488-01-0938 A</u>	17. INFORMANT Address <u>Mrs. Thomas J. Carter, 9731 Greystone Terr.</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>Cerebral Vascular occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Cerebro-Vascular arteriosclerosis</u>		
<p>CONDITIONS, if any, which have to do with the death, stating the date of living (last)</p> <p><u>OK</u> <u>Joseph M. Smith</u> <u>1/17/59</u></p>		<p>It had femoral head replacement 12-19-59 <u>Dis. neck Part. of.</u></p>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture femoral neck Rt. Prostate hypertrophy</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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>It fell in running hand</u>	
20c. TIME OF INJURY Hour <u>12</u> Month, Day, Year <u>12-17-59</u> a.m. p.m.			

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>06 5301 Page</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis,</u>	COUNTY	STATE <u>Mo.</u>
21. I attended the deceased from <u>12-17-59</u> to <u>1-4-60</u> and last saw her/him alive on <u>1-4-60</u> Death occurred at <u>12:30 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Carroll A. Smith M.D.</u>		22b. ADDRESS <u>3720 Washington</u>		22c. DATE SIGNED <u>1-4-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 8, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Arthur J. Donnelly 3840 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 6 1960</u>	26. REGISTRAR'S SIGNATURE <u>Carroll Smith, 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 _____

Licensed Embalmer No. 4699

P. O. Address 374 1/2

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.