

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960

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-60-003184

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>43 yrs</b>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>St. Louis-Little Rock Hosp, Inc.</b> INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3929 Maffitt</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Scott - Brisker</b>			4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coach Cleaner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Naborton, Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13a. FATHER'S NAME <b>?</b>		
13b. MOTHER'S MAIDEN NAME <b>Eliza</b>		14. NAME OF HUSBAND OR WIFE <b>Mattie Brisker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>702-16-6300</b>		17. INFORMANT Address <b>Mattie Brisker 3929 Maffitt Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastasis.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Papillary Carcinoma of bladder, ureters.</b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b>181.8</b>
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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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
21. I attended the deceased from <b>Oct. 1959</b> to <b>Jan. 20, 1960</b> and last saw <sup>next</sup> him alive on <b>1-20-60</b> . Death occurred at <b>1-20-60 11:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Charles Kromes M.D.</b> (Degree or title)			22b. ADDRESS <b>1755 S. Grand Blvd.</b>		22c. DATE SIGNED <b>1-21-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-25-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
24. FUNERAL DIRECTOR <b>James Randle &amp; Sons Funeral Directors</b> 3133 Bell, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. <b>JAN 23 1960</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b> E.P.	

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 Ester N. Harris

Licensed Embalmer No. 445

P. O. Address 4181 Wash

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.