

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-009120

FILED VS MAR 3 1960

317

Primary Registration District No. 53

Registrar's No. 619

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN University City		Length of stay in 1b 3 yrs.	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6600 Washington Ave.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6600 Washington Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Leora Middle Brown Last Brown			4. DATE OF DEATH Month February Day 23 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Macoupin Co., Ill.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Aaron Green		13b. MOTHER'S MAIDEN NAME Sarah Unknown		14. NAME OF HUSBAND OR WIFE John M. Brown		
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. Unknown		17. INFORMANT Address Aaron Brown, Rt. 1, Bethalto, Ill.		

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) Aproplexy			12 hrs.
DUE TO (b) Hypertension			10 yrs.
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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
21. I attended the deceased from 6:30 am to 6:40 and last saw her ^{her} _{him} alive on Feb. 19. 60 Death occurred at 6:40 am on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) J. P. Myers M.D.		22b. ADDRESS 5861 Plymouth Ave	22c. DATE SIGNED 2-23-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-26-60	23c. NAME OF CEMETERY OR CREMATORY Valhalla Memorial Park	23d. LOCATION (City, town, or county) (State) Godfrey, Ill.
24. FUNERAL DIRECTOR ADDRESS Smith Funeral Home, 2521 Edwards-Alton, Ill.		25. DATE RECD. BY LOCAL REG. 2-24-60	26. REGISTRAR'S SIGNATURE John C. Mumford M.D.

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 *H E Colquhoun*

Licensed Embalmer No. 5535

P. O. Address _____

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.