

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS MAR 24 1960

60-012385

2 2203

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 Mo b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS MO		Length of stay in 1b		c. CITY OR TOWN ST LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LOUIS CHRONI HOSPITAL			Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5220 DAVISON		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LILLIE Middle E Last BROWN			4. DATE OF DEATH Month 2 Day 23 Year 60					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-1-81	9. AGE (last birthday) 78	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) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MO		12. CITIZEN OF WHAT COUNTRY YES	
13a. FATHER'S NAME HENRY HEITGRASS			13b. MOTHER'S MAIDEN NAME ALVINA O'BERSCHEL		14. NAME OF HUSBAND OR WIFE DECEASED			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT Address MURRAY BROWN 5220 Davison Str.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Right Hip DUE TO (b) Generalized Arterio Sclerosis DUE TO (c) 903.7 44 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) When she came in contact							PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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 (Refer nature of injury in PART I or PART II of item 18.) in the kitchen patient and fell to the floor at Chronic Hospital on January 13 1960						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 1. 18 60	Month, Day, Year 18 1960	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, shop, office building, etc.) Shop	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTRY	STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. 6:50 P.M.								
22a. SIGNATURE (Degree or title) Patrick J. Taylor Carmel				22b. ADDRESS 1300 Clark			22c. DATE SIGNED 225 6.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/27/60	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park		23d. LOCATION (City, town, or county) st Louis County			(State)
24. FUNERAL DIRECTOR JOHN STYGAR & SON 5541 Riverview				25. DATE RECD. BY LOCAL REG. FEB 25 1960		26. REGISTRAR'S SIGNATURE Earl Smith. M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb.

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 J. M. Rister

Licensed Embalmer No. 3980

P. O. Address St. Louis

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.