

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 30 1960

60-013611  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 965

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Hts.</b>		Length of stay in 1b <b>2 Days</b>		c. CITY OR TOWN <b>Creve Coeur</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route #1 Mason Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>LYDA</b> Middle <b>A.</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1960</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-21-1886</b>		9. AGE (last birthday) <b>79</b>		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) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Oran, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Samuel Ancell</b>				13b. MOTHER'S MAIDEN NAME <b>Ada Kirk</b>				14. NAME OF HUSBAND OR WIFE <b>Late Basil Brown</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>None</b>		17. INFORMANT Address <b>Joseph A. Brown Route #1-Mason Rd.</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>RUPTURE ABDOMINAL AORTIC ANEURYSM</b> DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs</b> <b>10 yrs</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 checked="" 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 _____ a.m. _____ 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 <b>3-18-60</b> to <b>3-20-60</b> and last saw her <sup>her</sup> live on <b>3-20-60</b> . Death occurred at <b>8:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Martin H. Austin MD.</b>						22b. ADDRESS <b>634 N Grand Blvd</b>			22c. DATE SIGNED <b>3-21-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 23, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hiram Park Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>						
24. FUNERAL DIRECTOR <b>Kriegshauser 9450 Olive St. Road</b>				25. DATE RECD. BY LOCAL REG. <b>3-22-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy Md.</b>							

DOCUMENT

MEDICAL CERTIFICATION

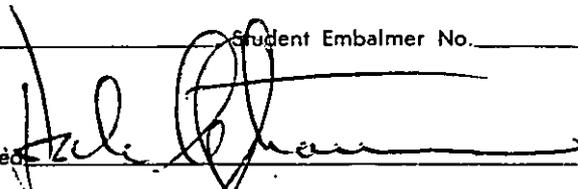
BY AFFIDAVIT OF

**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. 4533

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.