

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 18 1960

-60-016643

2 3735

STATE FILE NUMBER

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		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION INCARNATE WORD HOSP		d. STREET ADDRESS (If outside, give location) 3416 WINNEBAGO	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES BRINDA		4. DATE OF DEATH Month Day Year APRIL 1 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAR 23 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOX COVERER SCHLEICHER PAPER BOX		10b. KIND OF BUSINESS OR INDUSTRY MISSOURI	12. CITIZEN OF WHAT COUNTRY U-S-A
13a. FATHER'S NAME JOSEPH BRINDA		13b. MOTHER'S MAIDEN NAME MARY BOSEK	
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. 488-01-6391	17. INFORMANT Address MARY PUTTHOFF 3416 WINNEBAGO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BROUNCHO PNEUMONIA TERMINAL			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) CEREBRAL VASCULAR ACCIDENT 1 WK
DUE TO (c) ARTERIO SCLEROSIS 33 YRS			
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 checked="" 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 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 1957 to 4/1/60 and last saw ^{her} him alive on 4-1-60 Death occurred at 11:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J D Michael M.D.		22b. ADDRESS 812 Olive	22c. DATE SIGNED 4/2/60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APR 4 1960	23c. NAME OF CEMETERY OR CREMATORY ST. PETER + PAUL	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
24. GENERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. APR 4 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RM 957

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 J...

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.