

RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS MAY 25 1960

-60-020733

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5242 STATE FILE NUMBER

| | | | | | | |
|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis, Mo.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>5 1/2 S. Broadway</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>EDWARD BROWN</u> First Middle Last | | | 4. DATE OF DEATH <u>April 19 1960</u> Month Day Year | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/30/86</u> | 9. AGE (last birthday) <u>74</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>??</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>??</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | |
| 13a. FATHER'S NAME <u>James</u> | | 13b. MOTHER'S MAIDEN NAME <u>Susan Smith</u> | | 14. NAME OF HUSBAND OR WIFE | | |
| 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. <u>None</u> | 17. INFORMANT <u>St. Louis City Hosp. # 1</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u> DUE TO (b) <u>Chronic Pulmonary Disease</u> DUE TO (c) <u>527.2</u> 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) <u>Respiratory Throat</u> | | | | 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 <u>4/8/60</u> to <u>4/19/60</u> and last saw <u>him</u> alive on <u>4/19/60</u> Death occurred at <u>9:14 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Nicholas Owen M.D.</u> | | | 22b. ADDRESS <u>1515 Lafayette Ave.</u> | | 22c. DATE SIGNED <u>4/20/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>MAY 31 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Rowland Mortuary Svc. 4104-06 Manchester</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>MAY 19 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>m d</u> | | | |

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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.