

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024353

FILED VS. JUL 12 1960

318

Primary Registration District No. 1003

Registrar's No. 6413

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		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. Luke's Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1031 Goodfellow		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Belle Brockmeyer				4. DATE OF DEATH Month Day Year June 22, 1960				
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 12/19/07	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months 5 Days 27	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 At Home		11. BIRTHPLACE (City and state or country) Ireland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME James Ward			13b. MOTHER'S MAIDEN NAME Unknown			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.		17. INFORMANT John Brockmeyer 1031 Goodfellow 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>Bronche pneumonia - asperata</u> DUE TO (b) <u>Carcinoma of stomach with gastro-intestinal bleeding severe.</u> DUE TO (c) <u>151XF</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Became so weak that fell &amp; bruise neck</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							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>7-8 days</u>	
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. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell at home</u>					
20c. TIME OF INJURY Hour a.m. p.m. <u>6-9-60</u>	Month, Day, Year	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, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo</u>	STATE	
21. I attended the deceased from <u>June 10<sup>th</sup></u> to <u>June 21 1960</u> and last saw her <u>him</u> alive on <u>June 21 1960</u> Death occurred at <u>6:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>H K Roberts M.D.</u> (Degree or title)			22b. ADDRESS <u>1105 Central Clay St</u>			22c. DATE SIGNED <u>June 22 1960</u>		
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22e. DATE <u>6/24/60</u>	22f. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22g. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		22h. (State)		
24. FUNERAL DIRECTOR Chas. F. Stuart 1225 Union Bl.			25. DATE RECD. BY LOCAL REG. <u>JUN 23 1960</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m d s*

**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 Elton H. Remel

Licensed Embalmer No. 428

P. O. Address St. Louis

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