

URI DIVISION OF HEALTH -- STANDARD CERTIFICATE OF DEATH

-60-028166

FILED VS AUG 8 1960

318 Primary Registration District No. 1003

Registrar's No. 7445

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY None		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis, Mo.	
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hosp.		d. STREET ADDRESS (If outside, give location) 2632 No. Euclid	

3. NAME OF DECEASED (Type or print) First Mrs. Maggie Middle Bell Last Brown			4. DATE OF DEATH Month July Day 24 Year 1960			
5. SEX Female	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1869	9. AGE (last birthday) 91	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) Caloyoker, Tenn.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Unavailable		13b. MOTHER'S MAIDEN NAME Lizzie -Unavailable		14. NAME OF HUSBAND OR WIFE J. J. Brown		
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.		17. INFORMANT Address Joe J. Brown, 2632 Euclid Ave		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Hemorrhage?			3 hours
DUE TO (b) Arteriosclerotic & Hypertensive			
DUE TO (c) Vascular Disease			yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3 3 1 X			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 Month, Day, Year a.m. p.m.			
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 Coroner case and last saw her/him alive on 5.10 A on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Deceased or title) Maggie Brown	22b. ADDRESS Mo. Pac. Hosp	22c. DATE SIGNED 7/25/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/30/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) Berkeley City, Mo.

24. FUNERAL DIRECTOR ADDRESS Cunningham & Moore Undertaking Co. 2405 Marcus	25. DATE RECD. BY LOCAL REG. JUL 27 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

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 John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.