

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-039452**

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| AMENDED  | Registration District No. <u>317</u>   | Primary Registration District No. <u>541</u>  | Registrar's No. <u>2967</u>  | STATE FILE NUMBER  |   |
| DATE AMENDED   | FILED NOV 8 1961   |   |  |  |   |
|  | 1. PLACE OF DEATH<br>a. COUNTY <u>ST. LOUIS</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> COUNTY <u>ST LOUIS</u>                 |  |   |
|  | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON MO</u>  |   | Length of stay in lb <u>3 DAYS</u>   | c. CITY OR TOWN <u>WEBSTER GROVES MO</u>                         |   |
|  | c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis County</u>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>911 N. ELM</u>  |   |
|  | 3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Brefford</u> Last <u>Brefford</u>   |   | 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>61</u>  |  |   |
|  | 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>NEGRO</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/15/1907</u>                                | 9. AGE (last birthday) <u>54</u>          |
|  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>   | 11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>    | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
|  | 13a. FATHER'S NAME <u>NELSON BREFFORD</u>  |   | 13b. MOTHER'S MAIDEN NAME <u>MARY BROWN</u>  |  | 14. NAME OF HUSBAND OR WIFE <u>NONE</u>   |
|  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   | 17. INFORMANT <u>Julie Hill 66 Lincoln Webster Grove</u> Address |   |
|  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fatty metamorphosis of liver</u><br><u>malnutrition</u><br>DUE TO (b) <u>Chronic alcoholism</u><br>DUE TO (c) <u>Chronic alcoholism</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute adrenal insufficiency</u> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH          |
| 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 <u>9:45</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>  |  | Month, Day, Year <u>10-16-61</u>  |  |  |   |
| 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.)                  | 20f. CITY, TOWN, OR LOCATION   |  | COUNTY STATE                              |
| 21. I attended the deceased from <u>10-16-61</u> to <u>10-19-61</u> and last saw her/him alive on <u>10-19-61</u> .<br>Death occurred at <u>9:45</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |
| 22a. SIGNATURE <u>Arthur L. Howe mo.</u> (Degree or title)   |  | 22b. ADDRESS <u>60150 Brentwood Clayton Mo.</u>   |  | 22c. DATE SIGNED <u>10-21-61</u>                                 |   |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial Oct 23, 1961</u>   |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY <u>Fatheredicksons Crestwood Mo</u>   | 23d. LOCATION (City, town, or county) (State)                    |   |
| 24. (NEAR) DIRECTOR <u>D. H. Sanders &amp; Sons</u> ADDRESS <u>1776 E. Kelham</u>  |  | 25. DATE RECD. BY LOCAL REG. <u>10-23-61</u>  | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>   |  |   |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thodore J. Pausie

Licensed Embalmer No. 4243

P. O. Address 1306 E. 17th St.  
Hester, Iowa

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.