

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046120

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11536

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b 2 mos 10 das	c. CITY OR TOWN Webster Groves
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) No 10 Girard Dr
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) John Alfred Brooks	4. DATE OF DEATH Month 12 Day 10 Year 1961
--	--

5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1897	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
--------------------	------------------------------	---	---------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY SoWestern Bell Telephone	11. BIRTHPLACE (City and state or country) Bloomfield, Mo	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME Thomas Grant Brooks,	13b. MOTHER'S MAIDEN NAME Nellie Scism	14. NAME OF HUSBAND OR WIFE Mrs Bernice D Brooks
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW# 1	17. INFORMANT Mrs Bernice D Brooks # 10 Girard Dr
--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis	Webster Groves 19, Mo	INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) General Arteriosclerosis		5 years
DUE TO (c) 332+		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease Chronic	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Oct 1959 to Dec 1961	COUNTY St. Louis	STATE Mo
--	--	---	----------------------------	--------------------

21. I attended the deceased from Oct 1959 to Dec 1961 and last saw him alive on Dec 9, 1961 Death occurred at 1:50 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Marion W. Davis (Degree or title)	22b. ADDRESS 539 N. Grand	22c. DATE SIGNED 12/11/61
--	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-12-1961	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park	23d. LOCATION (City, town, or county) (State) St. Louis County Mo
---	--------------------------------	--	---

24. FUNERAL DIRECTOR Hoffmeister Colonial Mortuary 6464 Chippewa Street St. Louis 9 Missouri	25. DATE RECD. BY LOCAL REG. DEC 11 1961	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE FURNISHED

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 John L. Denne
Licensed Embalmer No. 4194
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.