

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020217

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4818** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAY 31 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2735 Stoddard</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Henry</b> Last <b>Brooks</b>			4. DATE OF DEATH Month <b>5</b> Day <b>9</b> Year <b>62</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			
8. DATE OF BIRTH <b>12-26-1893</b>		9. AGE (last birthday) <b>68</b>		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) <b>Had Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Contractors</b>			
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>Lemuel Brooks</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Brooks</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>yes WW I</b>						16. INFORMANT <b>Florence Brooks, 2735 Stoddard St</b>			17. ADDRESS			18. INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b>						DUE TO (b) <b>Congestive Heart Failure</b>						DUE TO (c) <b>434.1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 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 <b>5-7-62</b> to <b>5-9-62</b> and last saw him alive on <b>5-9-62</b>				Death occurred at <b>8:55</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <i>Sydney A. Fran</i> , M. D.		22b. ADDRESS <b>2601 N. Whittier Street</b>		22c. DATE SIGNED <b>5-9-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
<b>Removal</b>		<b>5/16/62</b>		<b>National Crematory</b>				<b>Jefferson Barracks, Mo</b>					
24. FUNERAL DIRECTOR ADDRESS <b>C.W. Roberts Ind. Co 1414 N. Taylor</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 11 1962</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>							

USE BLACK INK OR TYPEWRITER RIBBON



**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

*H. Claude Gordon*

Licensed Embalmer No.

*3489*

P. O. Address

*St. Louis, Mo*

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.