

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040042

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **9865** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 19 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY		St. Louis												
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		St. Anthony Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		10911 Oasis		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)						First			Middle			Last			4. DATE OF DEATH		Month		Day		Year	
Infant Matthew R. Brevard															Oct. 14, 1962							
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR										
male		white				Oct. 11, 1962		3		Months		Days		Hours		Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY										
none				none				St. Louis, Mo.				USA										
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE														
Robert Brevard				Shirley Burrows				none														
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				St. Louis, Mo.										
no				none				Robert Brevard				10911 Oasis										
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) <i>Kernicterus</i>												2 hrs.										
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												Bleeds										
DUE TO (b) <i>Erythroblastosis Fetalis</i>																						
DUE TO (c) <i>770.0</i>																						
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 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																		
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 <i>Oct 11, 1962</i> to <i>Oct 14, 1962</i> and last saw him alive on <i>Oct 14, 1962</i> Death occurred at <i>530 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.																						
22a. SIGNATURE <i>Chester P. Lynyville M.D.</i>						22b. ADDRESS <i>3438 S. Grand -</i>			22c. DATE SIGNED <i>10-15-62</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)															
removal		10-16-62		Resurrection Cem.			St. Louis County, Mo.															
24. FUNERAL DIRECTOR <i>Southern Funeral Home</i> <i>6322 S. Grand, St. Louis, Mo.</i>						25. DATE RECD. BY LOCAL REG. <i>OCT 15 1962</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>														

USE BLACK INK OR TYPEWRITER RIBBON

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DOCUMENT

MEDICAL CERTIFICATION

~~Dr. Watson?~~
Dr. Lyrrivler
3438 A. Young

after 2

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 Al Chandler

Licensed Embalmer No. _____

P. O. Address _____

Not Embalmed

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.