

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-004454

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 60

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JAN 25 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>             |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Moline Acres</b>   |   | Length of stay in 1b <b>3 months</b>   | c. CITY OR TOWN <b>Moline Acres</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>9854 Edgefield Drive</b>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <b>9854 Edgefield Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>         |
| 3. NAME OF DECEASED<br>(Type or print) First <b>Brian</b> Middle <b>J</b> Last <b>Fleming</b>   |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>1963</b>   |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b>   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>7-28-1957</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>  | 9. AGE (last birthday) <b>5 years</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.  |
| 11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>   |   | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME <b>Orland J. Fleming</b>   |   | 13b. MOTHER'S MAIDEN NAME <b>Dolores A. Allar</b>  | 14. NAME OF HUSBAND OR WIFE <b>none</b>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of ) <b>no</b>   |   | 16. SOCIAL SECURITY NO. [redacted]   | 17. INFORMANT Address <b>Mr. Orland Fleming, 9854 Edgefield Drive</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b>   |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral palsy</b>   |   |  | <b>5 yrs.</b>  |
| DUE TO (c)  |   |  |  |
| 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.<br><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 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>July 11 - 60</b> to <b>June 6 62</b> and last saw <sup>him</sup> alive on <b>5-14-62</b><br>Death occurred at <b>11 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |
| 22a. SIGNATURE (Degree or title) <b>Dr. Gust M.D.</b>   |   | 22b. ADDRESS <b>1453 Mc Jean</b>   | 22c. DATE SIGNED <b>1/7/63</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE <b>Jan 9 1963</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>   | 23d. LOCATION (City, town, or county) <b>Normandy, St. Louis Co., Mo</b>   |
| 24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave St. Louis, Missouri</b>  |   | 25. DATE RECD. BY LOCAL REG. <b>1-8-63</b>   | 26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>   |

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

*Julius R Brown*

Licensed Embalmer No.

*5146*

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.