

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-013066

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3368 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

FILED MAR 28 1963	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in 1b _____ c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST. LOUIS c. CITY OR TOWN FLORISSANT Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1660 TYSON DR. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle P. Last BROCKMEYER	4. DATE OF DEATH Month MARCH Day 21 Year 1963
5. SEX MALE	6. COLOR OR RACE WHITE
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1914
9. AGE (last birthday) 48	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) INSPECTOR-PUBLIC WORKS-CITY OF FLORISSANT ST. LOUIS, MO.
11. BIRTHPLACE (City and state or country) _____	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME JOHN BROCKMEYER	13b. MOTHER'S MAIDEN NAME BELLE WARD
14. NAME OF HUSBAND OR WIFE MARY ANN MUCCI 1332 LOUISVILLE AV	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. NONE
17. INFORMANT _____	Address 1332 LOUISVILLE AV
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEPATIC DECOMPENSATION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) LAENNEC'S CIRRHOSIS DUE TO (c) 581.1 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 INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years	
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 <u>3/19/63</u> to <u>3/21/63</u> and last saw her/him alive on <u>3/21/63</u> Death occurred at <u>1:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title) M.D.	22b. ADDRESS BARNES HOSPITAL
	22c. DATE SIGNED 3/21/63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR. 23, 1963
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
23d. LOCATION (City, town, or county) ST. LOUIS, MO. (State)	
24. FUNERAL DIRECTOR KRIEGSHAUSER 4228 S. KINGSHIGHWAY ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 22 1963
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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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 R. W. Storsand

Licensed Embalmer No. 4007

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.