

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017541

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4123** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300 Rev. 4/59

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AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED APR 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>205 No. 9th St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Willie (William) B. DeBrule</b>		4. DATE OF DEATH Month Day Year <b>April 11, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>2/14/1914</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotels</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>
13a. FATHER'S NAME <b>Charles DeBrule</b>		13b. MOTHER'S MAIDEN NAME <b>Vesta Ledford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. # 2</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Larline DeBrule, 205 No. 9th St.</b>		14. NAME OF HUSBAND OR WIFE <b>Larline DeBrule</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>aspiration of gastric contents - uremia</i> DUE TO (b) <i>Surgical Repair of wound</i> DUE TO (c) <i>Repair of upper abdominal ventral hernia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>2 days</i> <i>7 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Uremia, segmental osteoclasia, coronary insufficiency</i>			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 checked="" 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.) <b>560-3</b>	
20c. TIME OF INJURY Hour a.m. p.m.	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>April 3 - 1963</b> to <b>April 11 - 1963</b> and last saw him alive on <b>April 11 - 1963</b> Death occurred at <b>11:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert Rainey MD</i> (Degree or title)		22b. ADDRESS <b>100 N. Euclid Ave St Louis</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify): <b>Removal</b>		23b. DATE <b>4-13-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Liberty Baptist Church</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>		23d. LOCATION (City, town, or county) (State) <b>Lowe, Kentucky.</b>	
25. DATE RECD BY LOCAL REG. <b>APR 12 1963</b>		26. REGISTRAR'S SIGNATURE <i>Loard 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 Robert M. Murray

Licensed Embalmer No. 3749

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.