

MISSOURI DIVISION OF HEALTH -- STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8438-63-033472
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED AUG 22 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 17 years	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION COMMUNITY HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4832 St. Louis Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ocie C. Brooks			4. DATE OF DEATH Month Day Year August 17, 1963
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-20-1919
9. AGE (last birthday) 44		IF UNDER 1 YEAR Months Days Hours Min. 5	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY TOMPKINS TRUCKING CO. E. St. Louis, Ill	11. BIRTHPLACE (City and state or country) USA
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Charles Brooks	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Sarilla Young	14. NAME OF HUSBAND OR WIFE Loree Brooks
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of serv) Yes W. W. II		16. SOCIAL SECURITY NO.	17. INFORMANT Loree Brooks Address 4832 St. Louis
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:- IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Atherosclerosis DUE TO (c) 420.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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, Month, Day, Year 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 8/12/63 to 8/17/63 and last saw her alive on 8/16/63 Death occurred at 7:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) L. Lawrence Reed MD		22b. ADDRESS 5943 Cabonne St, St Louis	22c. DATE SIGNED 8/19/63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-19-63	23c. NAME OF CEMETERY OR CREMATORY Booker Washington	23d. LOCATION (City, town, or county) Centerville, Illinois
24. FUNERAL DIRECTOR NASH FUNERAL HOME ADDRESS 111 N. 13th St.		25. DATE RECD. BY LOCAL REG. AUG 19 1963	REGISTRAR'S SIGNATURE Earl Smith, M.D.

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *My Frances York*

Licensed Embalmer No. 4434
P.O. Address 117 N. 13th St. 84

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.

[Handwritten signature]