

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-045260

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11064**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH <b>NOV 22 1963</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <b>mo</b>	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St Louis</b>		Length of stay in lb <b>D.O.A</b>	c. CITY OR TOWN <b>St Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital #1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2231 Indiana</b>
3. NAME OF DECEASED (Type or print) <b>RICHARD ALBERT BRAND</b>			4. DATE OF DEATH <b>Nov 7 1963</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-1886</b>
9. AGE (last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 H.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tool maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and state or country) <b>St Louis mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		13. FATHER'S NAME <b>UNKNOWN BRAND</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. NAME OF HUSBAND OR WIFE <b>Sarah Brand</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT <b>Ed Wyland 2410 Louis</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
CONDITIONS, if any, which gave rise to above cause (a) <b>Arteriosclerotic Heart Disease -</b>			
DUE TO (b) <b>420.0</b>			
DUE TO (c) <b>Coronary Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension</b>			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 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>May 1959</b> to <b>Nov 7, '63</b> and last saw him alive on <b>9-17-63</b> Death occurred at <b>11:30 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Daniel L. DePue M.D.</b>		22b. ADDRESS <b>634 N. Pauline St. (S) St Louis</b>	
22c. DATE SIGNED <b>11-8-63</b>		22d. LOCATION (City, town, or county) (State) <b>St Louis mo</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-12-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis mo</b>
24. FUNERAL DIRECTOR <b>Carl Willemson 9409 Lackland</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 8 1963</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith 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 Earl Hellemann

Licensed Embalmer No. 3501

P. O. Address Orland Ave

63114

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.