

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7282**  
Registrar's No. **1761**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution:  
3817 Olive St  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 3817 Olive St.  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DAISY BROOKS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 4, 1884  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH, Month Feb day 20<sup>th</sup>  
year 1946 hour 11<sup>00</sup> minute P. M.  
21. I hereby certify that I attended the deceased from Dec 26 1946 to Feb 20 1946  
that I last saw h. or alive on Feb 15 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
61 3 16 hr. min.

Immediate cause of death  
Cardiac Failure  
Cardiac Dilatation  
Due to Myocarditis  
Due to Hypertension  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
12 hour  
12 hour  
5 years  
5 years

PHYSICIAN  
Underline the cause to which death should be charged statistically.

9. Birthplace: Streator Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Luther Carrington  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Josephine Dachesne  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
16. (a) Informant Helen Wallace  
(b) Address 3817 Olive St.  
17. (a) Removal (b) Date thereof 2-21-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Storm Lake, Iowa  
18. (a) Signature of funeral director Chulick Und. Co.  
(b) Address 1722 S. Jefferson Ave.  
19. (a) FEB 21 1946 J. F. Brudick  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_  
23. Signature Phil Papendick (M. D. or other) \_\_\_\_\_  
Address 3403 Olive St St Louis Mo Date signed 2/21/46

WRITE PLAINLY—USE UNFADING BACK INK—MAKE A PERMANENT RECORD

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Clayton Chick*.....

Licensed Embalmer No..... *4143*.....

P. O. Address..... *1722 S. Jff*.....

**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 this body is not embalmed, fact should be so stated above.**