No. 300
10.48

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20817

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4859

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 216 So Garrison

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY: ads

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 17

d. STREET ADDRESS (If rural, give location): 18 216 So Garrison 13

3. NAME OF DECEASED (Type or Print)
a. (First): Louise
b. (Middle):
c. (Last): Brisco

4. DATE OF DEATH (Month) (Day) (Year): June 1 1949

5. SEX: F 3
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct 30, 1892
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ark.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Rufus Johnson
13b. MOTHER'S MAIDEN NAME: Emma Reed
14. NAME OF HUSBAND OR WIFE: John W Brisco

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: John W Brisco — ADDRESS: 216 So Garrison

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardio Renal Vascular

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 121

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 442 X

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 12:50 P.M. from the causes and on the date stated above.*

23a. SIGNATURE: Joseph M. Quinn — Deputy Coroner 2 (Degree or title)
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 6/2/49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE: June 7/49
24c. NAME OF CEMETERY OR CREMATORY: Augusta Ark.
24d. LOCATION (City, town, or county) (State): Ark.

DATE REC'D BY LOCAL: JUN 3 1949
REGISTRAR'S SIGNATURE: J B Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE: F. A. Green — ADDRESS: 4214 Delmar

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK 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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Signed F. C. Green

Signed .....
Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4314 Delmar

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.