

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2322

State File No. \_\_\_\_\_

BIRTH NO. 367250 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 308

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>St Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>FIRMIN Delege</u>		d. STREET ADDRESS (If rural, give location) <u>5011 Elenore</u>	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <u>Newborn</u>		b. (Middle) <u>Brooks</u>	
c. (Last) <u>Brooks</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 10 50</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>infant</u>	8. DATE OF BIRTH <u>Jan 10 '50</u>
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>St. Louis</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>JOHN BROOKS</u>	13b. MOTHER'S MAIDEN NAME <u>MORAINCE CECILIA SHANNESKY</u>	14. NAME OF HUSBAND OR WIFE
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 <u>John Brooks 5011 Elenore</u>
18. CAUSE OF DEATH		18. ADDRESS

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) <u>Placenta Circumvallata with</u>		
	ANTECEDENT CAUSES <u>Premature labor (22 weeks) gest.</u>		
II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

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) <u>7615</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10, 1950, to 2/10, 1950, that I last saw the deceased alive on 1/10, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Kay V. Boecker MD</u> (Degree or title)	23b. ADDRESS <u>4500 Olive</u>	23c. DATE SIGNED <u>1/10/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JAN-12-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>
24d. LOCATION (City, town, or county) (State) <u>St Louis MO</u>		

DATE REC'D BY LOCAL <u>JAN 11 1950</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schur</u>	ADDRESS <u>3125 Lafayette Ave.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2019

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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.....

*No Embalming*

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *EJ Schmitt* .....

Licensed Embalmer No. ....

P. O. Address *3125 Lafayette*

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.