

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25455

FILED JUL 19 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 1619

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St Louis</u>  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>St Louis</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Clayton</u>   |                           | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Valley Park</u> <u>4751</u>                             |   |
| c. LENGTH OF STAY (in this place) <u>week</u>   |                           | d. STREET ADDRESS (If rural, give location) <u>General Delivery</u> <u>1</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Louis Co. Hospital</u>  |                           |   |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Christine</u>  |                           | b. (Middle) <u>Marie</u>  |   |
| c. (Last) <u>Brockman</u>   |                           | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7 - 1 - 50</u>  |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   | 8. DATE OF BIRTH <u>8-23-1914</u>                                 |
| 9. AGE (In years last birthday) <u>35</u>   |                           | IF UNDER 1 YEAR Months <u>10</u> Days <u>7</u>  | IF UNDER 24 HRS. Hours <u></u> Min. <u></u>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country) <u>Henryville, Tenn</u> |
| 12. CITIZEN OF WHAT COUNTRY?  |                           | 13a. FATHER'S NAME <u>Oscar Pruitt</u>  |   |
| 13b. MOTHER'S MAIDEN NAME <u>Nell Voss</u>  |                           | 14. NAME OF HUSBAND OR WIFE <u>Frank Brockman</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                           | 16. SOCIAL SECURITY NO. <u>414-05-6906</u>  |   |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Frank Brockman</u>   |                           | ADDRESS <u>Valley Park, Mo.</u>   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.  |                           | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>                              |   |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Chronic Glomerulonephritis</u>   |                           | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>  |   |
| DUE TO (c) <u></u>  |                           | Mo to yr. <u>59 2X</u>  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Rheumatic Heart Disease with Mitral Stenosis</u>   |                           | Years <u>4</u>  |   |
| 19a. DATE OF OPERATION  |                           | 19b. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           |   |   |
| 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)   |                           |   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)  |                           | 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 <u>6-26</u> , 19 <u>50</u> , to <u>7-1</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>50</u> , and that death occurred at <u>10 A. m.</u> , from the causes and on the date stated above. |                           |   |   |
| 23a. SIGNATURE (Degree or title) <u>Deurk Detting M.D.</u>  |                           | 23b. ADDRESS <u>Athens County Hospital</u>  |   |
| 23c. DATE SIGNED <u>7-2-50</u>  |                           |   |   |
| 24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>   |                           | 24b. DATE <u>7-3-50</u>   |   |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>   |                           | 24d. LOCATION (City, town, or county) (State) <u>Kirkwood</u>   |   |
| DATE REC'D BY LOCAL REG. <u>7-2-50</u>  |                           | REGISTRAR'S SIGNATURE <u>Herbert L. Souke M.D.</u>  |   |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis H. Bopp, Inc.</u>   |                           | ADDRESS <u>Kirkwood, Mo.</u>  |   |

(Licensed Embalmer's Signature on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

403

**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 .....  
Student Embalmer

Signature Robert DeBrouillet

Licensed Embalmer No. 3691

P. O. Address Richmond Heights, Mo

**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.