

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28076**
Registrar's No. **7222**

FILED AUG 25 1951

318

1003

BIRTH NO. 31716-57 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		e. STREET ADDRESS (If rural, give location) 2840 Henrietta	
3. NAME OF DECEASED (Type or Print) a. (First) MARY (FEMALE) b. (Middle) CELESTE c. (Last) BRAWLEY		4. DATE OF DEATH (Month) (Day) (Year) MAY 27 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 5-26-51
9. AGE (In years last birthday) 18		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Paul	
14. MOTHER'S MAIDEN NAME Mary Sparks		15. NAME OF HUSBAND OR WIFE	
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. 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, ashenia, etc. It means the disease, injury, or complication which caused death.		19. INFORMANT'S SIGNATURE OR NAME Hospital Record	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input 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) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 776X	
22. I hereby certify that I attended the deceased from 5-26-51 , 19___, to 5-27-51 , 19___, that I last saw the deceased alive on 5-27-51 , 19___, and that death occurred at 9:30A m. , from the causes and on the date stated above.			
23a. SIGNATURE Robert L. Korn M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 5-28-51		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 6 AUG 14 1951		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State)		24e. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	
24f. DATE REC'D BY LOCAL REG. AUG 14 1951		24g. REGISTRAR'S SIGNATURE J. B. [Signature]	

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.