

FILED FEB 25 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7385
Registrar's No. 1308

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 township) OR TOWN St. Louis c. LENGTH OF STAY (In this place) _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2213

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital d. STREET ADDRESS (If rural, give location) 21 802 7 Jefferson

3. NAME OF DECEASED a. (First) Howard b. (Middle) _____ c. (Last) Brinkley 4. DATE OF DEATH (Month) (Day) (Year) Jan. 22 1953

5. SEX Male 6. COLOR OR RACE Col 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 8. DATE OF BIRTH March 1, 1889 9. AGE (In years less birthday) 63 10. UNDER 1 YEAR 0 11. UNDER 1 HR. 0 12. UNDER 15 MIN. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State, or Foreign Country) Missouri 12. CITIZEN OF WHAT COUNTRY? U

13a. FATHER'S NAME George Brinkley 13b. MOTHER'S MAIDEN NAME Sallie Sargent 14. NAME OF HUSBAND OR WIFE Not known

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 Elizabeth Rhodes ADDRESS 2601 N Whittier St

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH Undet.
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) Undetermined
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

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) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 002X

22. I hereby certify that I attended the deceased from 1-11, 1953, to 1-22, 1953, that I last saw the deceased alive on 1-22, 1953, and that death occurred at 2:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edward B. Williams M.D. 23b. ADDRESS 2601 N Whittier St 23c. DATE SIGNED 1-29-53

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE 2-28-53 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. FEB 4 1953 REGISTRAR'S SIGNATURE Carl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE Rowland H. Manchester ADDRESS _____

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.

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.