

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26170**  
**6182**

FILED JUL 31 1953

BIRTH NO. **70904-53** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b> <b>2199</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hosp.</b>		d. STREET ADDRESS (If rural, give location) <b>19 4471 Olive St.</b>	
3. NAME OF DECEASED (Type or Print)	a. (First) <b>BART</b>	b. (Middle) <b>Allen</b>	c. (Last) <b>BROWN</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>11-17-52</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>7</b>   IF UNDER 1 YEAR <b>2</b>   IF UNDER 1 HRs. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS MO</b>
13a. FATHER'S NAME <b>JOHN BROWN</b>		13b. MOTHER'S MAIDEN NAME <b>JOAN BARTELSMEYER</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John Brown, 4471 Olive St.</b>

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
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b)		4 hrs.
ANTECEDENT CAUSES 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.		<b>Hemangioma scalp</b>		

19a. DATE OF OPERATION <b>19 June 53</b>	19b. MAJOR FINDINGS OF OPERATION <b>Hemangioma R. Occipital Area Scalp</b>		20. AUTOPSY? 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>228X</b>	

22. I hereby certify that I attended the deceased from **10 May, 1953** to **19 June, 1953**, that I last saw the deceased alive on **19 June, 1953**, and that death occurred at **2:00 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>James J. Dowdy M.D.</b>		23b. ADDRESS <b>3720 Washington Blvd.</b>		23c. DATE SIGNED <b>20 June 53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>6-27-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>	
DATE REC'D BY LOCAL REG. <b>JUN 22 1953</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>McKee Hills 2707 N Grand</b>		

(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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed. *Ronald O Yabank*

Licensed Embalmer No. *3917*

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.