

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**34600**

State File No. ....

FILED OCT 2 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 700 Registrar's No. 2480

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <u>2059</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN <b>Koch, Missouri</b>		c. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <u>3 weeks</u>		d. STREET ADDRESS (If rural, give location) <b>1423 Hodiament</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>			

<b>3. NAME OF DECEASED</b> a. (First) <b>Ben</b> b. (Middle) <b>(AKA Benjamin)</b> c. (Last) <b>Brody</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Sept. 20, 1953</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>7-4-98</b>	<b>9. AGE</b> (In years last birthday) <b>55</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 2 HRS: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Nix Clerk</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hat</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>St. Louis, Missouri</b>	
				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	

<b>13a. FATHER'S NAME</b> <b>Louis Brody</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Tilly Brody</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>NONE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>497-03-6849</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. Evelyn Levine</b>	
				<b>ADDRESS</b> <b>5859a Terry</b>	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 1/2 MOs.</b>	
<b>MEDICAL CERTIFICATION</b>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic pulmonary tuberculosis</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>002X</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	

22. I hereby certify that I attended the deceased from 8-4-53, 1953, to 9-29-53, 1953, that I last saw the deceased alive on 9-18-53, 1953, and that death occurred at 7:30p., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> <i>Elin S. Lipscomb M.D.</i> (Degree or title)		<b>23b. ADDRESS</b> <b>Robert Koch Hospital</b>		<b>23c. DATE SIGNED</b> <b>9-21-53</b>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24b. DATE</b> <b>9/21/53</b>		<b>24c. NAME OF CEMETERY OR CREMATION</b> <b>Beth Ham. Hag. Ladue, Mo.</b>	
		<b>24d. LOCATION</b> (City, town, or county) (State) (City, town, or county) (State)			

<b>DATE REC'D BY LOCAL REG.</b> <b>9/21/53</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Herbert R. ...</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Berger Memorial</b>	
				<b>ADDRESS</b> <b>4715 McPherson</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.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_  
*Edward J. Dwyer*  
Signed \_\_\_\_\_  
Licensed Embalmer No. *3988*

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.