

FILED MAR 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7275**

| | | | | | | | | |
|--|---|--|--|---|--|---|----------------------------------|---------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. 317 | | PRIMARY REG. DIST. NO. 500 | | Registrar's No. 457 | | |
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____ | | | | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN Normandy) | | c. LENGTH OF STAY (In this place) (1 week) | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Normandy Hospital | | | | e. STREET ADDRESS (If rural, give location) 4446 Dryden Ave. | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) B. c. (Last) Brooks; | | | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 18 1954 | | | | | |
| 5. SEX M | 6. COLOR OR RACE W. | 7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married | 8. DATE OF BIRTH Dec. 29 1901 | | 9. AGE (In years last birthday) 52 | | IF UNDER 1 YEAR Months Days | IF UNDER 1 HR. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Building | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME El Robert H Brooks; | | | 13b. MOTHER'S MAIDEN NAME Elizabeth Donnelly | | 14. NAME OF HUSBAND OR WIFE NONE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 704-12-7071 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beatrice Doyle 4446 Dryden | | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric Thrombosis ANTECEDENT CAUSES Thrombo. Embolic DUE TO (b) Phenomena DUE TO (c) Prostate Carcinoma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 Oct 9, 1953 , to Feb 18, 1954 , that I last saw the deceased alive on Feb 18, 1954 , and that death occurred at 3 pm. , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Dr. G. C. Olson D.O. | | | | 23b. ADDRESS 7283 Natural Bridge | | 23c. DATE SIGNED 2/19/54 | | |
| 24a. BURIAL / CREMATION REMOVAL (Specify) REMOVAL | | 24b. DATE 2/22/54 | 24c. NAME OF CEMETERY OR CREMATORY Calvary | | 24d. LOCATION (City, town, or county) (State) St. Louis Mo. | | | |
| DATE REC'D BY LOCAL REG. 2-19-54 | | REGISTRAR'S SIGNATURE Herbert R. Danks M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 N. Euclid Ave | | | | |

(Licensed Embalmer's Statement on Reverse Side)

SW

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

No. 300
10-48
0010

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.....
Signature of Student Embalmer

Signed. *Albert Mayfield*

Licensed Embalmer No. *30*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.