

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6767

State File No.

FILED MAR 1 1955

BIRTH NO. 58077-54 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 424

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Richmond Heights</u>) c. LENGTH OF STAY (If this place) <u>4 days</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY c. CITY OR TOWN <u>St. Louis</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>5865 Maple Avenue 2057</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Julie</u> b. (Middle) <u>Ann</u> c. (Last) <u>Brookes</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 - 17 - 1955</u>				
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>8 - 7 - 1954</u>	9. AGE (In years last birthday) <u>-</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James N. Brookes</u>		13b. MOTHER'S MAIDEN NAME <u>Mary M.</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James N. Brookes, 5865 Maple Ave.</u>			
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) <u>Congenital heart disease.</u> ANTECEDENT CAUSES <u>(transposition of aorta pulmonary stenosis septal defect)</u> DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Upper respiratory infection</u>				INTERVAL BETWEEN ONSET AND DEATH <u>From birth 4 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min.)		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 <u>8 - 25, 1954</u> to <u>2 - 17, 1956</u> , that I last saw the deceased alive on <u>2 - 17, 1956</u> and that death occurred at <u>2PM</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John H. Davis M.D.</u>		23b. ADDRESS <u>634 N. Grand</u>		23c. DATE SIGNED <u>2-18-56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/18/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>			
24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		DATE REC'D BY LOCAL REG. <u>2-18-56</u>		REGISTRAR'S SIGNATURE <u>Robert R. Pomke M.D.</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral</u>		ADDRESS <u>1905 Union Blvd.</u>					

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

Dr. Daniels
Mo Theatre Bldg. 1:30 - 3:30
35 N. Central, Clayton 9 - 11:30

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... *Warren A. Carver*
Licensed Embalmer No. *35*

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