

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 27 1955

State File No. 19905

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5212

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 OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 18 4447 Papin 21870	

3. NAME OF DECEASED (Type or Print) Birdie			4. DATE OF DEATH (Month) (Day) (Year) 6 13 55		
a. (First)	b. (Middle)	c. (Last) Brown	9. AGE (in years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOWED	8. DATE OF BIRTH 9-5-1878	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) St Louis MO		12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME ALLEN WILKINSON		13b. MOTHER'S MAIDEN NAME BETSY UNKNOWN		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JANICE CARTER 4147 PAPIN	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		Undt.	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		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.			

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? 331X	

22. I hereby certify that I attended the deceased from 5-14 1955, to 6-13 1955, that I last saw the deceased alive on 6-13 1955, and that death occurred at 7:50 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 6-14-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 6-18-55		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD	
24d. LOCATION (City, town, or county) (State) St Louis Co. MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennie Love 3103 Washington			
DATE REC'D BY LOCAL REG. JUN 16 1955		REGISTRAR'S SIGNATURE			

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.....
Signature of Student Embalmer

Signed *H. Claude Gord*.....

Licensed Embalmer No. *34*

P. O. Address *4575a*

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.