

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27485

FILED SEP 1 1955

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6716

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>St Louis</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer Phillips Hospital</u>		STREET ADDRESS (If rural, give location) <u>22 211 So 22nd 2229</u>	
3. NAME OF DECEASED (First) <u>Joyce</u> (Middle) <u>Marie</u> (Last) <u>Brown</u>		4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>22 Aug 1943</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>11</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
11a. BIRTHPLACE (City and State or Foreign Country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME	13b. FATHER'S MAIDEN NAME <u>Victoria Brown</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Victoria Brown</u> ADDRESS <u>211 So 22nd</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Traumatic Hemorrhage of the right lung, suffered when [crossed out] operated before [crossed out] Chandler (Col) went out of control and struck deceased on side of eye front of about 5' 20 22nd St, about 1210 am., July 30, 1955</u>		
	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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE OR HOMICIDE <u>Accidental</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <u>Street</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St Louis Mo 8124</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 30 55 12:10</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>25</u>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert E Taylor Coroner</u> (Degree or title)	23b. ADDRESS <u>1300 Clark</u>	23c. DATE SIGNED <u>8.3.55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>4 Aug 55</u>	24c. NAME OF SEMETERY OR CREMATORY <u>St Olive</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
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DATE REC'D BY LOCAL REG. <u>AUG 3 1955</u>	REGISTRAR'S SIGNATURE <u>Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Reliable Funeral Sys</u> ADDRESS <u>1221 No. Taylor</u>
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(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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Paul V. Freeman*

Licensed Embalmer No. *4686*

P. O. Address *4779 Hawaii*

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.