

34620

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1955

State File No. ....

9270

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hosp</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>21 3535 Page</b>		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <b>ROBERT</b>	b. (Middle)	c. (Last) <b>Brown</b>	<b>Oct 22 1955</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Apr 25 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>58</b>
11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Unknown</b>		<b>USA</b>	

13a. FATHER'S NAME <b>Unknown Brown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Helen Brown</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Helen Brown 3535 Page</b>
		ADDRESS

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL VASCULAR THROMBOSIS</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>CENTRAL NERVOUS SYSTEM SYPHILIS</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 <b>.026</b>	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) 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 July 1, 1955, to Oct 22, 1955, that I last saw the deceased alive on Oct 22, 1955, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph A. Ego</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>1325 So Grand</b>	23c. DATE SIGNED <b>10-24-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct 25 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St Matthews</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>

DATE REC'D BY LOCAL REG. <b>OCT 24 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E.J. Schnur</b>	ADDRESS <b>3125 Lafayette</b>
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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.....  
*Thomas R. Fenwick*

Licensed Embalmer No. *37*

P. O. Address *3125 Lafayette*

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.