

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

11880

State File No.

FILED MAR 22 1956

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **532**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY OR TOWN Koch		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 3 mo		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robt. Koch Hospital		e. STREET ADDRESS (If rural, give location) 3171 Branburien Place	

3. NAME OF DECEASED (Type or Print) a. (First) Chester b. (Middle) no middle name c. (Last) Brown			4. DATE OF DEATH (Month) (Day) (Year) Feb 20 56		
--	--	--	---	--	--

5. SEX M		6. COLOR OR RACE Poland		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 10-28-99		9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
------------------------	--	---------------------------------------	--	--	--	---	--	--	--	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborn			10b. KIND OF BUSINESS OR INDUSTRY Kaiser Coal Co.			11. BIRTHPLACE (City and State or Foreign Country) Mississippi			12. CITIZEN OF WHAT COUNTRY? U.S.		
--	--	--	---	--	--	--	--	--	---	--	--

13a. FATHER'S NAME Charles Brown			13b. MOTHER'S MAIDEN NAME Ida Carpenter			14. NAME OF HUSBAND OR WIFE Eva Braidy		
--	--	--	---	--	--	--	--	--

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. 486-16-3994		17. INFORMANT'S SIGNATURE OR NAME Koch Hospital Record, St. Louis, Mo.				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 8 mo	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 1-17-56		19b. MAJOR FINDINGS OF OPERATION Unresectable Carcinoma, Rt. Lung 162x						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) _____		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 1 Jan, 1956, to 20 Feb, 1956, that I last saw the deceased alive on 19 Feb, 1956, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE H. W. M. D. (Degree or title)			23b. ADDRESS Robt Koch Hospital			23c. DATE SIGNED 2-20-56		
--	--	--	---	--	--	--	--	--

24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 2-25-56		24c. NAME OF CEMETERY OR CREMATORY Parthar Dickson		24d. LOCATION (City, town, or county) St Louis Co.		(State) Missouri	
--	--	---------------------------------	--	--	--	--	--	--------------------------------	--

DATE REC'D BY LOCAL REG. 2-24-56		REGISTRAR'S SIGNATURE Herbert B. Rowland		25. FUNERAL DIRECTOR'S SIGNATURE D. Watkins		ADDRESS 2700 Thomsall			
--	--	--	--	---	--	-------------------------------------	--	--	--

89. (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 *Leroy W. Ginnis*
.....

Licensed Embalmer No. 4

P. O. Address 3880 E

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.