

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28163

FILED SEP 6 1956

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7250**

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Louis</u> <u>2059</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1</u> (If not in institution) Length of stay in 1b | | d. STREET ADDRESS <u>5724 Cabanne Av.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>BOBBIE</u> Middle Last <u>BROWN</u> | | | 4. DATE OF DEATH <u>AUGUST 4, 1956</u> Month Day Year |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/2/83</u> |
| 9. AGE (In years last birthday) <u>73</u> | | IF UNDER 1 YEAR Month <u>5</u> Day <u>2</u> | IF UNDER 24 HRS. Hour <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At. Home</u> | 11. BIRTHPLACE (City and state or country) <u>Carruthersville Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Robert Franklin</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mission Catlin</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> <u>None</u> | |
| 16. SOCIAL SECURITY NO. <u>490228396A</u> | | 17. INFORMANT <u>Andy Brown Jr.</u> Address <u>5724 Cabanne Av.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Gen. arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | <u>420.0</u> | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from <u>7/12/56</u> to <u>8/4/56</u> and last saw her/him alive on <u>8/4/56</u> Death occurred at <u>7:10 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Glenn Schaefer M.D.</u> | | 22b. ADDRESS <u>1515 LAFAYETTE AVE.</u> | 22c. DATE SIGNED <u>8/4/56.</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>8/7/56</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Pagedale Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Bull Campbell Mort. 5165 Delmar</u> | | 25. DATE RECD. BY LOCAL REG. <u>AUG 6 1956</u> | 26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Neal Morris*

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

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.