

FILED APR 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14506

STATE FILE NUMBER

 Registration District No. 318 Primary Registration District No. 1003 Registrar 3091

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock Hill</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony's Hosp.</u>		Length of stay in 1b <u>10 days</u>	d. STREET ADDRESS (If outside, give location) <u>1201 Santa Fe Dr.</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBIN</u> Middle <u>W.</u> Last <u>BRITTAN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1949</u>		9. AGE (In years last birthday) <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>West Plains, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Howard Brittan</u>			14. MOTHER'S MAIDEN NAME <u>Jean Heuschele</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>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Howard Brittan,</u> Address <u>above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c)]					INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngospasm & brain spasm</u>					
DUPLICATE CAUSE (b) <u>Post poliomyelitis and brain damage</u>					
DUPLICATE CAUSE (c) <u>Post poliomyelitis and brain damage</u>					<u>2 years</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: (Indicate position given in Part I (a)) <u>post operation 3 days - spinal fusion</u>					
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.) <u>081x</u>		
20c. TIME OF INJURY Hour <u>8:40</u> Month <u>8</u> Day <u>40</u> Year <u>54</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.) <u>6-1-54</u>		20f. CITY, TOWN, OR LOCATION <u>4-28-57</u>	
21. I attended the deceased from <u>6-1-54</u> to <u>4-28-57</u> and last saw her alive on <u>8:40</u> <u>8:40</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Edwin G. Eigel M.D.</u>			22b. ADDRESS <u>3209 So. Grand Blvd. St. Louis, Mo.</u>		22c. DATE SIGNED <u>3-29-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-30-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>JAY B. SMITH, Maplewood, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>MAR 30 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300
158

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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APR 30 1957

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. Burgess*

Licensed Embalmer No. *402*

P. O. Address *Maplewood*

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.