

FILED JUN 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 022377

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5520**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis Mo.		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 09 DePaul Hosp		d. STREET ADDRESS (If rural, give location) 2061 2815 N. Kingshighway	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) F. c. (Last) B. BROWER		4. DATE OF DEATH (Month) (Day) (Year) 6-11-57	
5. SEX F M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 7, 1871
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. BIRTHPLACE (State or foreign country) Grafton - Ill.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William O'Neill		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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 ADDRESS Neil Brower Features - Mo.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH several weeks
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min)	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 **Jan 1955**, to **6/11/57**, 19___, that I last saw the deceased alive on **6/11/57**, 19___, and that death occurred at **2:45 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) McSherran M.D.	23b. ADDRESS 4339 Natural Bridge	23c. DATE SIGNED 6/2/57
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6/14/57	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis Mo.	25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS Carl Smith M.D. St. Louis Capital City Mo.	

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. 3481

working under my personal supervision.

Student
Student Embalmer

Signed Gentry R. Polito

Licensed Embalmer No. 3481

P. O. Address Crystal City

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 this body is not embalmed, fact should be so stated above.