

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47 022380  
STATE FILE NUMBER  
5458

FILED JUN 20 1957

Registration District No. 31E Primary Registration District No. 1003 Registrar's No. 5458

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>Dade</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Miller</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b <b>1 Hrs.</b>	d. STREET ADDRESS (If outside, give location) <b>Dade Co.</b>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CARROLL</b> Middle <b>H.</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>8</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-1915</b>	9. AGE (In years last birthday) <b>42</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Ava, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Roy Brown</b>			14. MOTHER'S MAIDEN NAME <b>Anna Darrow</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Juanita Brown, Miller, No.</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE TUBULAR NECROSIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
DUE TO (b) <b>RUPTURED CECUM, ABDOMINAL HEMORRHAGE</b>					
DUE TO (c)					
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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 <b>U. a. m.</b>					
20d. INJURY OCCURRED WHILE AT <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 <b>JUNE 8, 1957</b> to <b>JUNE 8, 1957</b> and last saw her alive on <b>JUNE 8, 1957</b> Death occurred at <b>10:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Conrad T. Rouse</b> M.D.			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>6/9/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-9-57</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Ava, Missouri.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b> 4700 Washington,		25. DATE RECD. BY LOCAL REG. <b>JUN 11 1957</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith No 190</b>	

Health, Welfare, Public Service  
00-56  
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

Page

Address

Name

X

X

X

Page Co.

I Pre.

JUN 2 1957

AUG 13 1957

1-30-1957

White

Male

U.S.A.

Address

Address

Address

Address

Address

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed Robert M. Murr Licensed Embalmer No. 3749

P. O. Address St. Paul

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.

Robert M. Murr, 1000 Washington