Health, Welfare Public Service

300 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33282

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8330

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, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☑ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 27 Homer Phillips — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 212 5158 Cabanne — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Norbert Middle Last Brockman

4. DATE OF DEATH: Month 9 Day 3 Year 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1901

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): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Barr Branch Library

11. BIRTHPLACE (City and state or country): Miseville, Miss.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Brockman

14. MOTHER'S MAIDEN NAME: Charity —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 494-09-8028

17. INFORMANT: Carrie Brockman — Address: 5158 Cabanne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral hemorrhage

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 331 X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her/him alive on _____. Death occurred at 9:40 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph M. Lucas Deputy Coroner

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 9/5/57

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 9-9-57

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: Geo. W. Bruce — ADDRESS: 4469 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: SEP 5 '57

26. REGISTRAR'S SIGNATURE: J. Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

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 Frederick P. Star

Licensed Embalmer No. 4

P. O. Address Sh. La

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.