

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1957

State File No. **33291**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8842**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 23 St. John's Hospital		e. STREET ADDRESS (If rural, give location) 2210 6216 Wanda Ave	
3. NAME OF DECEASED (Type or Print) a. (First) LLOYD b. (Middle) E. c. (Last) BROWN		4. DATE OF DEATH (Month) (Day) (Year) 9-19-1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-14-1892
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (City and State or Foreign Country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. NAME OF HUSBAND OR WIFE Katherine C. Brown	
13a. FATHER'S NAME Albert Brown		13b. MOTHER'S MAIDEN NAME Cora Kilgore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 488-10-2961	
17. INFORMANT'S SIGNATURE OR NAME Katherine C. Brown		ADDRESS 6216 Wanda Ave	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart failure (cont) ANTECEDENT CAUSES DUE TO (b) Aortic stenosis DUE TO (c) Aortic sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 421.1	
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)		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 8/7 ¹⁹⁵⁴ 8/19 , 19 57 , that I last saw the deceased alive on 8/19 , 19 57 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE O.P.J. Falk		23b. ADDRESS 18 S. Kings Highway	
23c. DATE SIGNED 9/20/57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-23-1957	
24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) 10160 Gravois Road Mo	
DATE REC'D BY LOCAL REG. SEP 20 57		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith	
REGISTRAR'S SIGNATURE Carl Smith		ADDRESS 6409 Gravois Ave	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. O. P. J. Falk Montclair Apts.

(Licensed Embalmer's Statement on Reverse Side)

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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..... *Jan M. Seymour*

Licensed Embalmer No. 4343

P. O. Address *St. Louis*

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.