

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1957

37215

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9858

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hamilton Med. Ctr.</b>			Length of stay in 1b <b>4 1/2 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>3904 Shaw Blvd.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RILEY</b> Middle <b>T.</b> Last <b>BROCK</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20,</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-24-1857</b>		9. AGE (In years last birthday) <b>100</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>Insurance Agent</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>General Ins.</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sylvester George</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Poole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>491-16-9749</b>		17. INFORMANT <b>7019<sup>th</sup> Mardel Mrs. G. F. BURTS, St. Louis, Mo.</b>		
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 Myocarditis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary-Heart-Vascular</b> DUE TO (c) <b>Disease present</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4-26-57</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>442+</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			COUNTY
21. I attended the deceased from <b>4-26-57</b> to <b>10-20-57</b> and last saw her alive on <b>10-3-57</b> Death occurred at <b>9:00</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>John + Flynna B. MD M.D.</b>				22b. ADDRESS <b>1715 So. 39th St. St. Louis, Mo.</b>		22c. DATE SIGNED <b>10-21-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-22-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 22 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

**STATEMENT BY LICENSED EMBALMER**

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

by me, or by ..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Allen Lane* .....

Licensed Embalmer No. *403* .....

P. O. Address *St. Louis* .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F**  
**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.**