

pt. Health,
, & Welfare
S. Public
alth Service

S. 300
ev. 1-5

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46546
STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 541 Registrar's No. 3002

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN Clayton, Missouri. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital DoA Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 6529 Bartmer Avenue., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Earl Middle W. Last Brown			4. DATE OF DEATH Month November Day 26 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1897		9. AGE (In years last birthday) 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Workers		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and state or country) Nauvoo, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Brown			14. MOTHER'S MAIDEN NAME Jane Milne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. # 1		16. SOCIAL SECURITY NO. 329-03-6007	17. INFORMANT Address Harriet S. Brown, 6529 Bartmer, U. City, Mo			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia secondary to carbon monoxide poisoning		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUPLICATE TO (b)	
	DUPLICATE 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 type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inhaled carbon monoxide poisoning	
20c. TIME OF DEATH Hour Month Day Year 3:30 P.M. 11/26/57		
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.) family car in garage	20f. CITY, TOWN, OR LOCATION COUNTY STATE University City St. Louis Mo.

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated

22a. SIGNATURE (Degree or title) Harriet S. Brown Coroner 3	22b. ADDRESS Clayton, Mo.	22c. DATE SIGNED 12/2/57
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-29-57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. 11-29-57	26. REGISTRAR'S SIGNATURE Robert R. Donkela
---	---	---

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 *Melvin L. Keimpe*

Licensed Embalmer No. *406*

P. O. Address *4911 Washington St. St. Louis, Mo.*

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.