

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007329
STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1723

300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri.			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
38. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ^{D.C.H.} INSTITUTION St. Louis Childrens Hospital		Length of stay in 1b 1990	d. STREET ADDRESS 4443 Pershing, Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bradley Dean Helm			4. DATE OF DEATH Month Day Year Feb. 12, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1958	9. AGE (In years last birthday)	10. UNDER 1 YEAR Months Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo. Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Grover Helm		13b. MOTHER'S MAIDEN NAME Marilyn Stroup		14. NAME OF HUSBAND OR WIFE Nil.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Grover Helm, 4443 Pershing, Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interstitial Pneumonitis</i>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) _____ DUE TO (c) _____					7630	
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"/>	
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 _____ and last saw her alive on _____ Death occurred at <i>6:25 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>James M. Kelly Brown</i>		(Degree or title) <i>Deputy</i>	22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>2-13-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>2-15-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Local Cemetery</i>		23d. LOCATION (City, town, or county) <i>Robertsville, Mo.</i> (State)		
24. FUNERAL DIRECTOR <i>Albert H. Hoppe</i>		ADDRESS <i>1700 Washington, Blvd.</i>	25. DATE RECD. BY LOCAL REG. <i>FEB 13 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Copy by Aff.
6/5/1958 B.S.

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.

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 *By W. Wilkinson*

Licensed Embalmer No. *3575*

P. O. Address *M. Jones*

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.

11A
rd
8607
111