

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008321

STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 465

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u> </u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hosp.</u>			Length of stay in lb <u>9 mos. 6 days</u>		d. STREET ADDRESS <u>4319 St. Louis</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHESTER</u> Middle <u> </u> Last <u>BROOKS</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-5-09</u>		9. AGE (In years last birthday) <u>48</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Zack Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Ammie Harvey</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>427-01-9475</u>		17. INFORMANT Address <u>Koch Hospital records, Koch, Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u>493XA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Pulmonary Tuberculosis.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u> </u> Month, Day, Year a. m. <u> </u> p. m. <u> </u>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <u>4-30-57</u> to <u>2-6-58</u> and last saw <u>him</u> alive on <u>2-6-58</u> Death occurred at <u>3:00</u> Pm on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Bernard Swanson, M.D.</u>				22b. ADDRESS <u>Robert Koch Hosp. Koch, Mo.</u>			22c. DATE SIGNED <u>2-6-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Railroad</u>		23b. DATE <u>2/12/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeler</u>		23d. LOCATION (City, town, or county) (State) <u>Okolona Mississippi</u>				
24. FUNERAL DIRECTOR <u>Herman J. Smith</u>			ADDRESS <u>4247/w Labadie Ave</u>		25. DATE RECD. BY LOCAL REG. <u>2-10-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Danke M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes.

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 *H. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575 Al*

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.