

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045443

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12784

5. 300
1-57
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

| | | | | | | | |
|--|---------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN ST. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 4242 West Lexington | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bessie Brasell | | | | 4. DATE OF DEATH Month Day Year 12 30 58 | | | |
| 5. SEX Female 3 | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-15-1888 | 9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months 3 Days 15 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Memphis Tenn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Henry Brooks | | | 13b. MOTHER'S MAIDEN NAME Anna Brown | | 14. NAME OF HUSBAND OR WIFE Edward Brasell | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Hershel Anderson 4242 W Lexington | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE & CHRONIC CHOLESTEROL HEPATITIS | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) MASSIVE ANASARCA. | | | | | | undet. | |
| DUE TO (c) 592X | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CIRRHOSIS OF THE LIVER. | | | | | | 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 Month, Day, Year a.m. p.m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 12-29-58 2:30P to 12-30-58 4:45P last saw her alive on 12-30-58 | | | | Death occurred at 4:45 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Paul A. Larson, M.D. | | | 22b. ADDRESS 2601 Whittier Street | | | 22c. DATE SIGNED 1-2-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-5-59 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. | | 23d. LOCATION (City, town, or county) (State) Berkley Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Houston Funeral Home 2814 Thomas St. | | | 25. DATE RECD. BY LOCAL REG. JAN 5 59 | 26. REGISTRAR'S SIGNATURE [Signature] | | | |

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 *Arthur L. Hellraid*

Licensed Embalmer No. *4221*

P. O. Address *3100 Easton*

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.