

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002781

STATE FILE NUMBER

2 566

FEB 3 1959 Registration District No. Primary Registration District No. Registrar No.

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Clair	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		d. STREET ADDRESS (If outside, give location) none given	
3. NAME OF DECEASED (Type or print) Barbara Kaye Brown		4. DATE OF DEATH Month January Day 15 Year 1959	
5. SEX Female	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 Jan. 1, 1959
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months 14 Days	IF UNDER 24 HRS. Hours 14 Min.
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) Washington, Missouri
12. CITIZEN OF WHAT COUNTRY? United States		13a. FATHER'S NAME Floyd Thomas Brown	
13b. MOTHER'S MAIDEN NAME Edna Johnson		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT EMorsech-500 South Kingshighway Blvd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized debility DUE TO (b) Disseminated salivary gland virus disease DUE TO (c) Post-op splenectomy for hypersplenism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post-op splenectomy for hypersplenism			INTERVAL BETWEEN ONSET AND DEATH 15 days 15 days
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Jan. 1, 1959 to Jan. 15, 1959 last saw her alive on Jan. 15, 1959 Death occurred at 7:05 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Richard H. Harty M.D.</i>		22b. ADDRESS 500 South Kingshighway Blvd.	
22c. DATE SIGNED 1/15/59		23a. BURIAL, CREMATION, REMOVAL (Specify) removal	
23b. DATE 1-16-59		23c. NAME OF CEMETERY OR CREMATORY Reedville Church Cemetery	
23d. LOCATION (City, town, or county) Sullivan, Missouri		(State)	
24. FUNERAL DIRECTOR H.M. Eaton Sullivan, Missouri		25. DATE RECD. BY LOCAL REG. JAN 16 59	
26. REGISTRAR'S SIGNATURE <i>Carl Smith mo</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Not Embalmed - Janner TV*

• Licensed Embalmer No.....

P. O. Address.....

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.