

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002785
STATE FILE NUMBER

FILED JAN 28 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 368

300
-57
7
7
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Length of stay in lb 1 mo.	d. STREET ADDRESS (If outside, give location) 2069 ADDRESS 4821 Cupples Pl.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Katie Brown			4. DATE OF DEATH Month Day Year 1-8-59		
--	--	--	--	--	--

5. SEX female	6. COLOR OR RACE 3 col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-79	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
------------------	----------------------------	---	------------------------------	---------------------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY? 0 USA
---	-----------------------------------	---	---------------------------------------

13a. FATHER'S NAME ? Johnson	13b. MOTHER'S MAIDEN NAME Heager Johnson	14. NAME OF HUSBAND OR WIFE --
---------------------------------	---	-----------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	Address
---	-------------------------	-----------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pt. Lower Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 490X	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease - Ins		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 9:10 a.m. 12-9-58 to 1-8-59 and last saw her alive on 1-8-59 Death occurred at 9:10 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John W. Beckman, M.D.	(Degree or title) C	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 1/8/59
---	---------------------	------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL Removal	23b. DATE 1-14-59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) Berkeley, Mo.
--	----------------------	---	--

24. FUNERAL DIRECTOR A.L. Beal Und. Co.	ADDRESS -4303 Delmar	25. DATE RECD. BY LOCAL REG. JAN 12 '59	26. REGISTRAR'S SIGNATURE Earl Smith MD
--	-------------------------	--	--

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 G. D. R. [Signature]

Licensed Embalmer No. 2728
P. O. Address 265 [unclear]

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.