

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006936

STATE FILE NUMBER

2 1800

FILED MAR 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57

6
8

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>East St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS <u>3123 Converse Ave.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA WASHINGTON BROWN</u>			4. DATE OF DEATH <u>FEBRUARY 18, 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>3/20/1934</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>East St. Louis, Illinois</u>	
			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>LUVADA WASHINGTON</u>		13b. MOTHER'S MAIDEN NAME <u>MATTIE LEAVELL</u>		14. NAME OF HUSBAND OR WIFE <u>ROOSEVELT BROWN</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>Unknown</u>		17. INFORMANT <u>Roosevelt Brown</u> Address <u>3123 Converse East St. Louis, Ill.</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>PULMONARY INFARCT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
DUE TO (b) <u>RHEUMATIC HEART DISEASE</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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 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 FEB 12, 1959 to FEB. 18, 1959 and last saw her alive on FEB. 18, 1959
Death occurred at 5:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. E. Vermillion, M.D.</u> (Degree or title)		22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>2/19/59</u>	
--	--	--	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/22/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Garden of Memory</u>		23d. LOCATION (City, town, or county) (State) <u>Stookey Township, Illinois</u>	
--	--	-----------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR <u>Marion's Office</u>		ADDRESS <u>2114 Mo. Ave East St. Louis, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 20 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	
--	--	--	--	---	--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Page 11 - 11/10/68

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 *Frank Prokop pf*

Licensed Embalmer No. *4356*

P. O. Address. *St. Louis, Mo*

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.