

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010750  
STATE FILE NUMBER  
2535

300  
1-57  
26  
3 P  
00

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**  
a. COUNTY \_\_\_\_\_  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST. LOUIS** Inside Limits Yes  No   
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **ST. LOUIS CITY H OSP. #1** Length of stay in lb **1 yr.**

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)  
a. STATE **Missouri** b. COUNTY **St. Louis**  
c. CITY OR TOWN **Pine Lawn** Inside Limits Yes  No   
d. STREET ADDRESS **6005 St. Lo Court** Reside on Farm Yes  No

**3. NAME OF DECEASED** First **ROBERT** Middle **Glasco** Last **BROWN**

**4. DATE OF DEATH** Month **3** Day **10** Year **59**

**5. SEX** **Male** **6. COLOR OR RACE** **Negroid** **7. MARRIED**  NEVER MARRIED  WIDOWED  / DIVORCED  **8. DATE OF BIRTH** **May 5, 1919** **9. AGE** (In years last birthday) **39** IF UNDER 1 YEAR: Months \_\_\_\_\_ Days \_\_\_\_\_ Hours \_\_\_\_\_ Min. \_\_\_\_\_ IF UNDER 24 HRS: \_\_\_\_\_

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **10b. KIND OF BUSINESS OR INDUSTRY** **Military** **11. BIRTHPLACE** (City and state or country) **New York, New York** **12. CITIZEN OF WHAT COUNTRY?** **USA**

**13a. FATHER'S NAME** **Robert Brown** **13b. MOTHER'S MAIDEN NAME** **Lorraine Parrott** **14. NAME OF HUSBAND OR WIFE** **Virginia B. Brown-wife**

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) **yes** **16. SOCIAL SECURITY NO.** **21 May 42 - 2 Feb 47 - 5 Dec 47 - 10 Mar 59** **17. INFORMANT** **Virginia B. Brown, St. Louis, Missouri** 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) **acute myocardial infarction** INTERVAL BETWEEN ONSET AND DEATH **momentary**  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **thrombosis of coronary artery** **unk.**  
DUE TO (c) **coronary arteriosclerosis** **unk.**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

**19. WAS AUTOPSY PERFORMED?** YES  NO  **2**

**20a. ACCIDENT**  **SUICIDE**  **HOMICIDE**  **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.) **420-1**

**20c. TIME OF INJURY** Hour \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. \_\_\_\_\_

**20d. INJURY OCCURRED WHILE AT**  NOT WHILE WORK  AT WORK  **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** **2-20-59** to **3-10-59** and last saw her alive on **3-10-59**  
Death occurred at **5:15 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

**22a. SIGNATURE** **Jean A. Chapman, M.D.** (In degree or title) **22b. ADDRESS** **1515 Lafayette Ave,** **22c. DATE SIGNED** **3-10-59**

**23a. BURIAL, CREMATION, REMOVAL (Specify)** **Removal** **23b. DATE** **3/12/59** **23c. NAME OF CEMETERY OR CREMATORY** **Arlington National** **23d. LOCATION (City, town, or county)** **Arlington, Virginia** (State) \_\_\_\_\_

**24. FUNERAL DIRECTOR** **P. W. Schildknecht, O'Fallon, Illinois** **25. DATE RECD. BY LOCAL REG.** **MAR 12 '59** **26. REGISTRAR'S SIGNATURE** **Earl Smith, M.D.**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 <sup>not</sup> embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Phillip H. Salikowski* .....

Illinois Licensed Embalmer No...8549.....

P. O. Address...O'Fallon, Illinois

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.