

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011085

STATE FILE NUMBER

FILED MAR 18 1959

Registration District No.

Primary Registration District No.

Registration No. 1954

300
1-57
3
1
6
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>University City</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Little Flower Conv. Hm.</u>		Length of stay in lb <u>2yrs</u>	
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>BRASSER</u> Last <u>KERR</u>		4. DATE OF DEATH <u>Feb. 24, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>New Amsterdam, Wisc.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Cornelius Brassier</u>		13b. MOTHER'S MAIDEN NAME <u>Diane Corre</u>	
13c. NAME OF HUSBAND OR WIFE <u>Frank Kerr</u>		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) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Margaret Kerr</u>		Address <u>7558 Drexel</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>Cerebral thrombosis (Fecorrot)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>			<u>20 yrs</u>
DUE TO (c) <u>Rt. Hemiplegia - August 1955</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <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 <u>6 March 1954</u> to <u>24 Feb 1959</u> and last saw him alive on <u>23 Feb 1959</u> Death occurred at <u>1:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. W. [Signature] MD</u>		22b. ADDRESS <u>320 Washington St. Louis 8, Mo</u>	
22c. DATE SIGNED <u>2/24/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Feb. 24/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ht. Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chicago, Ill.</u>	
24. FUNERAL DIRECTOR <u>Alexander & Sons 6175 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 24 '59</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr Robt W Kelly
3710 Washington
Je 3-1918

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Room 618

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 *Jos. E. McEllick*

Licensed Embalmer No. *2460*

P. O. Address *125 Duane*

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.