

Health, Welfare & Public Service

FILED JUN 15 1959  
Unit #A-324

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019962  
STATE REGISTRATION NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1466

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>GIDEON</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS. ADM. HOSP.</b>		Length of stay in lb <b>19 DAYS</b>	0728 STREET ADDRESS (If outside, give location) <b>BOX 283</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CALVIN</b> Middle <b>C</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> , Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 6, 1890</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>ANNA, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>CALVIN C. BROWN</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>ERNESTINE BROWN</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, JEFFERSON BARRACKS, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC DECOMPENSATION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	<b>3 Years</b>
	DUE TO (c) _____	<b>4 200</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Right Middle &amp; Lower Lobe Atelectasis with bronchial compression by Anthracotic nodes</b>		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.)
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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
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21. I attended the deceased from <b>MAY 7, 1959</b> to <b>MAY 26, 1959</b> Resided at <b>11:25 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>W. Oppler, Dir. Fed. Services</b> (Degree or title)	22b. ADDRESS <b>M.D. VAH, JEFFERSON BARRACKS, MO.</b>	22c. DATE SIGNED <b>5-27-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/27/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gideon, Mo</b>	23d. LOCATION (City, town, or county) (State) <b>Gideon, Mo</b>
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24. FUNERAL DIRECTOR <b>Edward Fendler 5611 South Grand Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>5-27-59</b>	26. REGISTRAR'S SIGNATURE <b>J. M. H. [Signature]</b>
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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 *J. A. Humphrey* .....

Licensed Embalmer No. *477* ✓

P. O. Address *St. Louis* .....

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.